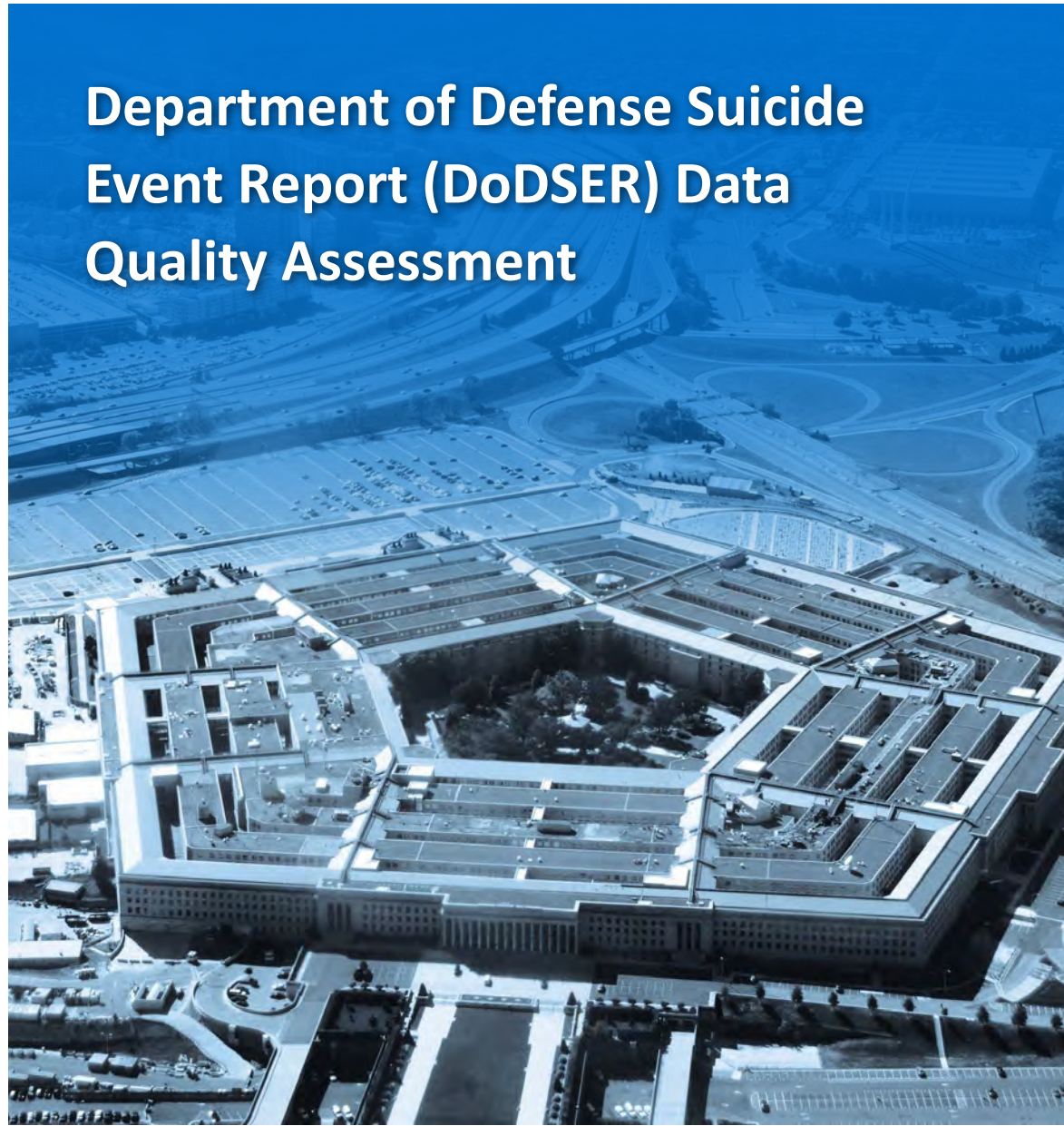




INSPECTOR GENERAL

U.S. Department of Defense

NOVEMBER 14, 2014



Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment

INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

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INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

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Results in Brief

Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment

November 14, 2014

Objective

The Department of Defense Suicide Event Report (DoDSER) is the system of record for health surveillance related to suicide ideations, attempts, and deaths. This assessment focused on decreasing the number of “don’t know” responses on suicide death submissions by identifying changes to policy, training, or oversight. We also examined the sharing of DoD medical information with the Department of Veterans Affairs (VA).

Observations

We identified seven topics for DoDSER submissions improvement:

- DoDSERs are submitted prematurely,
- DoDSER data collection is stovepiped,
- technical questions presented challenges for non-technical DoDSER submitters,
- user/commander feedback on DoDSER data is limited,
- Military Crisis Line staff lacks access to relevant military healthcare information,
- DoDSER data is not shared with the VA, and
- Military Criminal Investigative Organizations participation in the DoDSER process is inconsistent.

Recommendations

We recommend the Department of Defense improve the processes for collecting DoDSER information and submitting DoDSER data:

- Submit final DoDSER data after the Armed Forces Medical Examiner has completed the death investigation.
- Establish a multidisciplinary team approach to data collection to ensure accuracy.
- Improve subject matter expert participation in DoDSER data collection process.
- Empower local commanders to use DoDSER data to produce reports specific to their units/locations.
- Authorize the VA’s Military Crisis Line staff to access relevant healthcare information.
- Provide appropriate DoDSER data to the VA to use in their public health surveillance.
- Update Service policies to specifically encourage participation of Military Criminal Investigative Organizations in the DoDSER submission process.

Management Comments

We received comments from the Under Secretary of Defense for Personnel and Readiness, the Services, and the Military Criminal Investigative Organizations. Management concurred with all 16 recommendations.

We request the Director of the Defense Health Agency provide additional information in response to Recommendations 5 and 6. These comments are required by December 15, 2014.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Under Secretary of Defense for Personnel and Readiness		1.a, 2.a, 3.a, 4.a
Director, Defense Health Agency	5, 6	4.b
Director, National Center for Telehealth and Technology		3.b, 3.c, 4.c, 4.d,
Army Chief of Staff		1.b, 2.b, 3.d, 4.e
Chief of Naval Operations		1.b, 2.b, 3.d, 4.e
Commandant of the Marine Corps		1.b, 2.b, 3.d, 4.e
Air Force Chief of Staff		1.b, 2.b, 3.d, 4.e
Commanding General United States Army Criminal Investigation Command		7
Director of the Naval Criminal Investigative Service		7
Commander, Air Force Office of Special Investigations		7

Provide management comments by December 15, 2014.



**INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500**

November 14, 2014

MEMORANDUM FOR DISTRIBUTION

**SUBJECT: Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment
(Report No. DoDIG-2015-016)**

We are providing this report for review and comment. The DoDSER assessment focused on policy, training, and software improvements that would enhance the value of responses in the DoDSER annual reports received and used by DoD leadership for suicide related decision-making.

We considered management comments to a draft of this report when preparing the final report. We request the DHA Director provide additional information on Recommendations 5 and 6 in response to the final report. We should receive your comments by December 15, 2014. Your comments should describe what actions you have taken or plan to take to accomplish the recommendations and include the completion dates of your actions. Please send copies of documentation supporting the actions you may have already taken.

We will follow-up on other recommendations, as required, in accordance with DoD Directive 7650.3.

Please provide comments that conform to the requirements of DoD Directive 7650.3, which requires that recommendations be resolved promptly. Additional comments should be in electronic format (Adobe Acrobat file only) to SPO@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Please direct questions to [REDACTED] at [REDACTED] or [REDACTED] at [REDACTED]. We will provide a formal briefing on the results if management requests.

A handwritten signature in black ink, reading "K. P. Moorefield", is positioned above the printed name.

Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations

Distribution:

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House Committee on Armed Services

House Committee on Appropriations, Subcommittee on Defense

Contents

Introduction	1
Data Collection and Analysis Methodology	7
Noteworthy Practices	11
Observations	
Observation 1. DoDSERs Were Submitted Prematurely	13
Observation 2. DoDSER Data Collection is Stovepiped	19
Observation 3. Insufficient Information to Answer Technical Questions	25
Observation 4. Limited User Feedback and Empowerment	31
Observation 5. Military Crisis Line Lacks Access to Relevant Service Member Information	37
Observation 6. DoDSER Data is Not Shared with the VA	41
Observation 7. Inconsistent Military Criminal Investigative Organizations Participation in DoDSER Process	45
Appendixes	
Appendix A. Scope and Methodology	51
Appendix B. Quantitative Analysis of Data	54
Appendix C. Proposed DoDSER Submission Checklist	60
Appendix D. DoDSER CY 2012 Annual Report	62
Management Comments	65
Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs	65
Director, National Center for Telehealth and Technology	71
Army Chief of Staff	74
Chief of Naval Operations	75
Commandant of the Marine Corps	80
Air Force Chief of Staff	81
Commanding General United States Army Criminal Investigation Command	85
Director of the Naval Criminal Investigative Service	86
Commander, Air Force Office of Special Investigations	88
Acronyms and Abbreviations	89



Introduction

Objective

The objective of the Department of Defense Suicide Event Report (DoDSER) assessment was to determine why the Calendar Year (CY) 2011 DoDSER Annual Report had a high number of “don’t know/data unavailable” responses to questionnaire items. This assessment focused on the CY 2011 DoDSER Annual Report because it was the most recent DoDSER annual report at the time of our site visits.¹

This assessment addressed the potential impact that improved DoDSER data accuracy could have on informing DoD decision makers about changes to suicide prevention programs or policy. Incomplete data about suicide risk factors and contributing stressors² may hinder senior leaders from developing and implementing effective suicide prevention programs.

This assessment was intended to identify changes in policy, training, or oversight of DoDSER submissions that could decrease the number of “don’t know/data unavailable” submissions.

During the course of the assessment, we identified a particularly serious suicide prevention problem that presented a substantial and specific danger to public health and safety. We expanded the objective of the assessment to determine whether DoD was appropriately transmitting relevant service treatment records to the Department of Veterans Affairs (VA). Accordingly, we expanded the scope to include sharing of medical records and health surveillance information with the VA for the purpose of suicide prevention.

¹ The CY 2012 DoDSER Annual Report was released on April 25, 2014 and is discussed in detail in Appendix D.

² Also known as life stressors, typically include non-medical issues such as financial difficulties and relationship failures.

Background

DoD experienced an increased rate of suicide deaths from 2001 through 2012. For example, DoD's active Component rate has increased from 16.1 per 100,000 service members per year in 2008 to 22.7 per 100,000 service members per year in 2012. The following table indicates the most recent suicide death rates for DoD's active Components.³

Table 1: Suicide Rate for DoD and Each of the Services

Active Component	CY 2010 Rate*	CY 2011 Rate*	CY 2012 Rate*
DoD (All Services)	17.5	18.0	22.7
Army	21.7	22.9	29.7
USMC	17.2	14.9	24.3
Navy	11.1	15.0	17.8
USAF	15.5	13.3	15.0

*Rates per 100,000 service members per year

Source: 2012 DoDSER

In spite of the increased rate of suicide in the Armed Forces, suicide remains a relatively rare event. Most military bases or units suffer a small number of suicide deaths each year. This makes it extremely difficult to capture lessons learned on suicide risk factors at the local level. Conclusions based on a small number of suicide cases could misinform leaders and result in less successful suicide prevention efforts.

"[T]he entire DoD community . . . must demonstrate our collective resolve to prevent suicide, to promote greater knowledge of its causes and to encourage those in need to seek support."

Secretary of Defense, The Honorable Chuck Hagel

³ Army, USMC, Navy, and Air Force active Component suicide deaths for all geographic locations.

Leaders must have reliable information on suicide risk factors to make appropriate decisions related to suicide prevention efforts. It is critical to use standardized public health surveillance methods to gather appropriate information across the Armed Forces. DoDSER is the standardized public health surveillance database used by all Services for these suicide prevention analysis efforts.

Prior to the creation of the DoDSER in 2008, each of the Services used their own data collection methods. Their collection systems were not standardized or interoperable. As a result, it was not possible to aggregate and analyze data at the DoD level.

A DoD-led working group identified the common data requirements for inclusion in the DoDSER. The Services retained the ability to identify and collect Service-specific information in the DoDSER. DoDSER was designed to be Web-based in order to facilitate standardized, decentralized data entry. This standardization allows a common framework for reporting DoD trend analysis.

The DoDSER database includes information on suicide attempts and suicide deaths. The DoDSER gathers demographic data, contextual factors (location of event, duty environment, other), clinical health factors (history of self-harm behavior, behavioral health history, medical history, other), developmental factors (failed relationship, family history, legal history, other), and military history (demotions, military justice actions, deployment history, other).

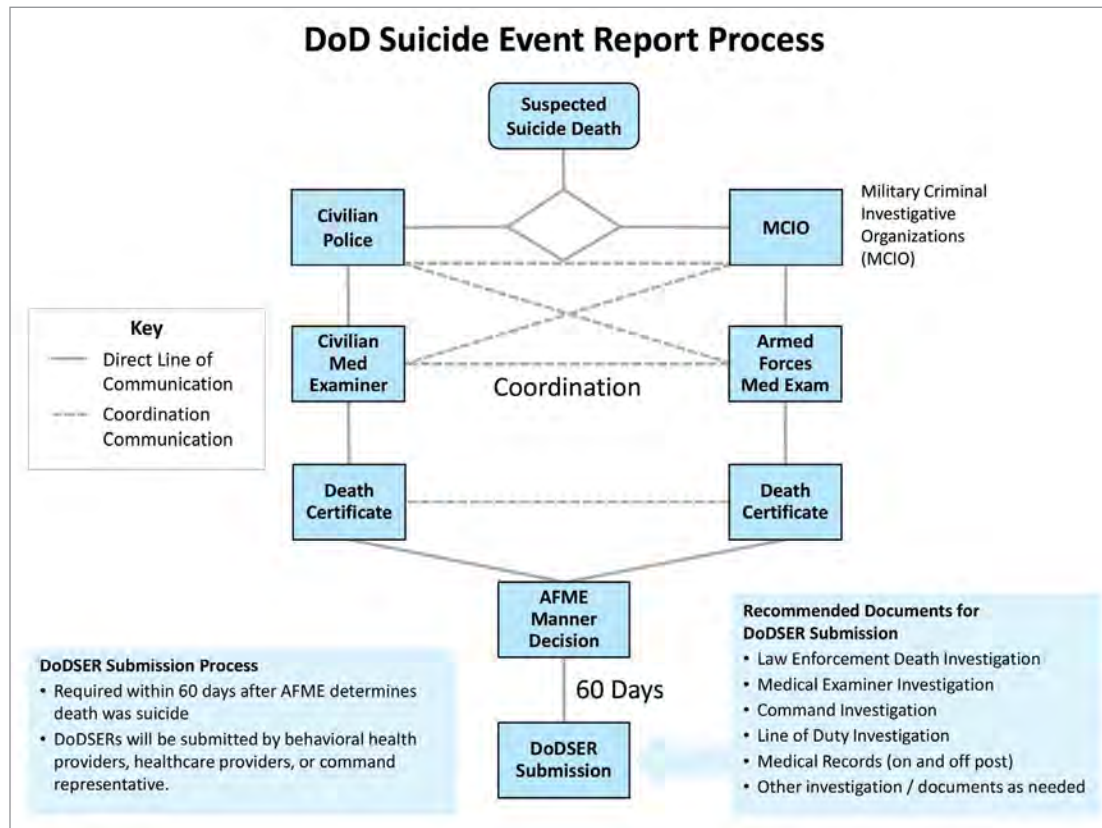
DoD's National Center for Telehealth and Technology serves as the program manager for DoDSER. They are responsible for maintaining the DoDSER coding manual and DoD training, both of which are available online through the National Center for Telehealth and Technology (<https://dodser.t2.health.mil/>). They compile and analyze the DoDSER submissions to produce an annual report.

The DoDSER Submission Process for Suicide Deaths

The DoDSER data collection process for a death submission begins when a unit suspects it may be a result of suicide. Every non-combat death is required to be investigated by a law enforcement agency to assist in determining the cause (for example, gunshot, asphyxia) and manner (for example, suicide, homicide). A medical examiner or coroner usually conducts an autopsy and other medical-forensic examinations. For service members on active duty, the Armed Forces Medical Examiner (AFME) either issues a final ruling or reviews a local medical examiner's

ruling on the cause and manner of death. The DoDSER final data submission is not required by DoD until after the AFME determines the death was suicide.⁴ This process is portrayed in Figure 1 on page 4.

Figure 1. DoDSER Process



Source: DoD IG-SPO

Once AFME has ruled the death a suicide, they notify DoD and Service representatives that a DoDSER submission is required. A representative is designated at the unit or installation level, depending on Service policy, to collect DoDSER information. Once this DoDSER submitter has finished gathering information, they submit the DoDSER via the National Center for Telehealth and Technology website. The individual responsible for submitting the DoDSER must complete DoDSER training prior to their first submission.

The DoDSER submitter is encouraged to seek information from the medical record, personnel record, autopsy, command investigations, and law enforcement investigations. The DoDSER submitter is also encouraged to interview the decedent's coworkers, supervisors, commanders, healthcare providers, and family members if necessary.⁵

⁴ Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, Subject: Standardized Reporting of Department of Defense Suicides and Department of Defense Suicide Event Report (October 14, 2009).

⁵ The Navy and USMC do not conduct interviews with family members.

DoDSER Data Issues

The 2011 DoDSER Annual Report had numerous critical data fields with a high number of “don’t know/data unavailable” responses. Table 2 presents the top 10 DoDSER items that had the highest percentage of “don’t know/data unavailable.”

Table 2. Highest DoDSER “Don’t Know” Items as a Percentage of CY 2011 DoDSER Submissions (n=287)

Rank	Percent Missing	DoDSER Item
1	60.8	Prior to the event, was the decedent an alleged or confirmed victim of emotional abuse?
2	57.3	Prior to the event, was the decedent seen by chaplain services?
3	56.5	Did the decedent have a family history of mental illness?
4	53.8	Prior to the event, was the decedent seen by a Military Treatment Facility?
5	53.8	Personnel Reliability Program (PRP) at the time of the event?
6	49.3	Prior to the event, was the decedent seen by substance abuse services?
7	47.7	Prior to the event, was there evidence of a failed or failing other relationship? (non-romantic)
8	47.7	Prior to the event, was there evidence of a completed suicide by a friend?
9	47.6	Prior to the event, had the decedent taken psychotropic medications?
10	47.6	During the event, was alcohol used?

Source: National Center for Telehealth & Technology

Because of these “don’t know/data unavailable” responses, it has been difficult for DoD to identify the critical risk factors that may contribute to suicide. Several civilian communities have used improved death-reporting data to develop targeted suicide screening and outreach efforts for high-risk populations. Therefore, it is reasonable to assume the military could do the same with improved data quality.

Scope

This assessment only examined the processes for suicide death cases. The assessment addressed the policy, software, and training related to DoDSER submission requirements. It used existing data sources, including law enforcement investigations, command investigations, and medical/health records, to draw conclusions about the availability of information that can be used to support DoDSER data requirements.



Data Collection and Analysis Methodology

This assessment used a multidisciplinary approach consisting of military medicine, public health, and military criminal investigation expertise to analyze the high number of “don’t know/data unavailable” responses in the CY 2011 DoDSER Annual Report. We reviewed Federal Government publications, DoD policy, and relevant civilian and military scientific literature related to suicide data collection and surveillance. We collected information on different DoDSER policies and procedures from the Services and Military Criminal Investigative Organizations through data calls, site visits, interviews, and briefings to the DoD Inspector General’s assessment team.

Assessment Phases

This assessment had two phases. Phase 1 consisted of a review of Military Criminal Investigative Organization suicide death investigations to determine the availability of information relevant to DoDSER submissions. The goal of this phase was to determine whether “don’t know/data unavailable” responses in DoDSER were due to a lack of available information (for example, evidence not available for recovery), or if the information was available but did not make it into the DoDSER system due to gaps in policy and/or breakdown in processes or procedures.

“Consistent suicide-related data can help public health practitioners better understand the scope of the problem, identify high-risk groups, and monitor the effects of suicide prevention programs.”

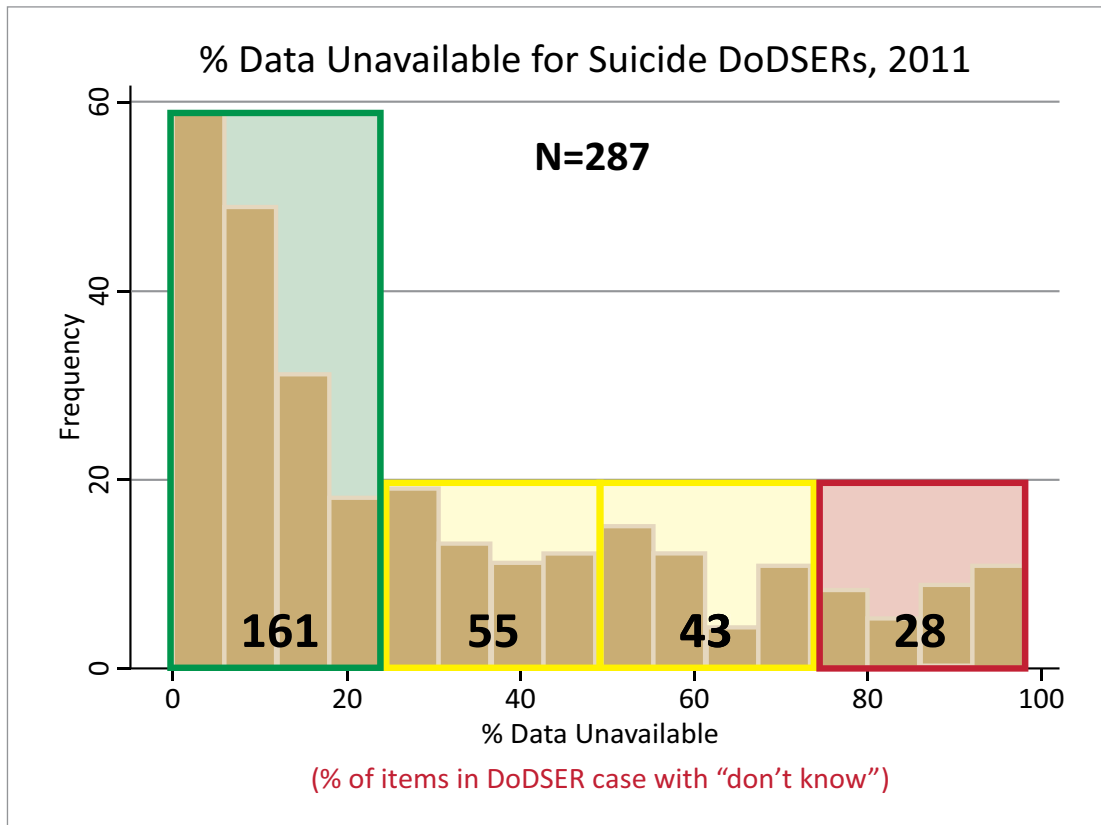
National Strategy for Suicide Prevention

There were 287 suicide death cases in the 2011 DoDSER Annual Report. All 287 cases were analyzed based on the percentage of questionnaire items marked “don’t know/data unavailable” per case. These cases were split into four groups (see Figure 2):

- 0-25 percent data unavailable (161 cases) (shaded in green),
- 25-50 percent data unavailable (55 cases) (shaded in yellow),
- 50-75 percent data unavailable (43 cases) (shaded in yellow), and
- 75-100 percent data unavailable (28 cases) (shaded in red).

The 0-25 percent data unavailable group (161 cases) were the most complete cases and were used as an example for best practices, but merited no further analysis for the purpose of this assessment.

Figure 2. CY 2011 DoDSER Death Cases Split Into Four Groups



Source: National Center for Telehealth & Technology

We analyzed the 2011 DoDSER submissions to determine which questions were most often marked “don’t know/data unavailable.” Questions that were most often marked “don’t know/data unavailable” and also determined to be relevant to this assessment were included in the data set for review. Appendix B presents a more detailed discussion of this process.

Phase 1 of the assessment included two distinct methodological steps. Step 1 used the most incomplete DoDSER cases (28 cases with 75 percent or more “don’t know/data unavailable”) and required close examination of each case. Step 2 of the analysis used a random stratified sample of cases from the two middle groups (98 cases with between 25 to 75 percent “don’t know/data unavailable”) to assess a representative sample of DoDSER submissions.

Suicide Death Investigation Review

For both steps of Phase 1, the review included Military Criminal Investigative Organizations’ (MCIO)⁶ death investigations because of our supposition that much of the missing DoDSER data could be found in death investigation case files. Additionally, all three Service MCIO’s headquarters (where the death investigation case files are archived) are co-located in Quantico, Virginia. Therefore, the assessment team determined that reviewing MCIO’s death investigations would be an effective and efficient method for uncovering missing DoDSER information.

Step 1 of the data analysis was conducted on the 75-100 percent data unavailable group (28 cases). This group had between 57 and 75 items of about 80 items marked “don’t know/data unavailable” (each Service had slightly different Service-specific items, which makes the overall number of questions vary slightly). We were concerned that these DoDSER submissions may have represented deaths in which the remains were not recovered or other extreme circumstances. We viewed these 28 DoDSER submissions as outliers because of the high percentage of missing information and therefore analyzed this data separately.

Based on our analysis of data obtained in Step 1, we concluded that information was available for most of the DoDSER data points from these 28 cases. One hundred percent of the cases had a completed death investigation, 86 percent of the cases had an autopsy report, 71 percent had a toxicology report, and 54 percent included medical information. Most of the data required for DoDSER submissions was available from the death investigation. Therefore, these 28 submissions should have been more complete.

Step 2 of the data analysis combined the 25-50 percent data unavailable (55 cases) group with the 50-75 percent data unavailable (43 cases) group to create a group of 25-75 percent data unavailable (98 cases). A random sample of 52 cases stratified by Service was taken from these 98 cases. A more detailed discussion of sample selection can be found in Appendix B.

⁶ The Military Criminal Investigative Organizations conduct law enforcement investigations into most noncombat deaths of service members. An expanded explanation of their responsibilities in suicide death investigations is provided in Observation 7.

This group of cases was used for the sample selection because they represented an active attempt to submit the required DoDSER information. However, barriers to collecting or submitting the information existed based on the number of “don’t know/data unavailable” items.

The findings in Step 2 of the analysis show that the “don’t know/data unavailable” percentage was greatly reduced by reviewing Military Criminal Investigative Organizations’ death investigations. Selected findings are presented in Table 3; detailed findings are presented in Appendix B.

Table 3. Results of Suicide Death Investigation Review

DoDSER Item	52 Sample 2011 DoDSER percent “Don’t Know” Before MCIO* Death Investigation Review	52 Sample 2011 DoDSER percent “Don’t Know” after MCIO* Death Investigation Review
Alcohol Involved	46.15	7.69
Prescription Involved	48.08	11.54
Current Behavioral Health Care	21.15	5.77

*Military Criminal Investigative Organization (MCIO)

Source: DoD IG

Phase 2 of the assessment consisted of site visits at six military installations with qualitative interviews and root cause analysis to identify potential barriers to accurate DoDSER data submission.

Conclusion

This methodology demonstrated that it is possible to improve DoDSER submissions with relevant and readily obtainable information using existing data sources (for example, the death investigation or medical examiner report). Our analysis indicated the additional information we obtained from reviewing the death investigations presented a more complete understanding of risk factors for suicide death in the military.

Having an enhanced understanding of suicide risk factors would better inform DoD policy makers and could ultimately improve Service suicide prevention programs. This report’s observations and recommendations are intended to improve DoDSER submission processes in order to help DoD refine suicide prevention programs.

Noteworthy Practices

We identified several noteworthy practices during the military site visits that merit consideration for implementation across the Services.

Team Approach to Suicide Prevention Lessons Learned

Several locations had adopted a community-based, multi-disciplinary approach to gathering lessons learned on suicidal behavior. These locations organized forums that typically included unit leadership (both officer and non-commissioned officers), medical and behavioral health personnel, local law enforcement personnel, and other community-based support services (for example, family advocacy, Red Cross, food locker).

This approach fostered collaboration and information sharing across agencies that routinely work with service members. It enabled leaders to identify high-risk behavior that, when viewed in isolation, may not have been obvious.

Service-level DoDSER Oversight

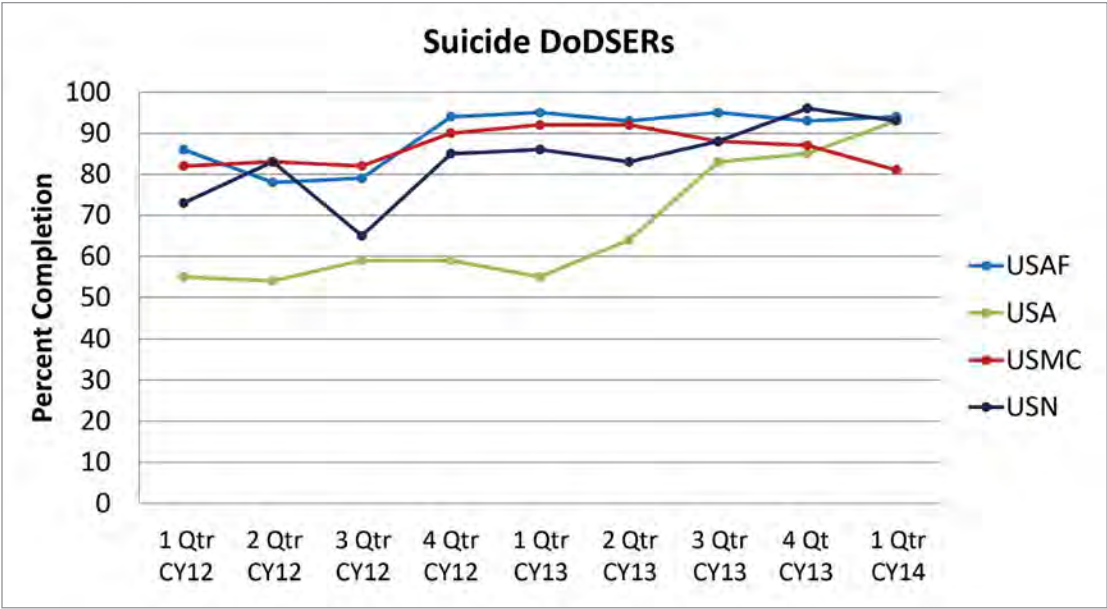
Several of the Services adopted specific organizational methods for monitoring DoDSER submissions. Depending on the needs of the Service, these methods ranged from the creation of an office with staff to specifying an additional duty within an existing office. This additional oversight at the Service-level, combined with the DoD-level improvements in the following paragraph, appeared to have helped improve data quality.

DoD-level Submission Improvements

The National Center for Telehealth & Technology, which manages the DoDSER program, began providing feedback to the Services on the quality of DoDSER submissions in September 2013. They created a dashboard on the DoDSER website that allowed the Service program managers to improve their oversight activities.

The overall quality of DoDSER submissions has improved since this dashboard initiative started. In the 3rd quarter of CY 2012, the average DoDSER submission for the Army and Navy was less than 70 percent complete. By the 1st quarter of CY 2014, both Services had increased to an average of more than 90 percent. This improvement in data submission is shown in Figure 3 on page 12.

Figure 3. DoDSER Submission Quality



Source: Data provided by National Center for Telehealth & Technology

Observation 1

DoDSERs Were Submitted Prematurely

DoDSER data was submitted before medical examiners and law enforcement agencies had finished their investigations.

DoDSER data was submitted earlier than required by DoD (60 days after AFME determined the manner of death to be suicide).

- U.S. Navy and U.S. Marine Corps policy required DoDSER submissions within 60 days or less from the date of death.
- DoDSERs were submitted in the other Services earlier than required by Service policy.

DoDSER accuracy suffered from a high number of “don’t know/data unavailable” responses because toxicology, forensic investigations, etc. were still being processed.

Applicable Criteria

DoD Directive 6490.14, “DoD Suicide Prevention Program,” June 18, 2013, established the policy for the Defense Suicide Prevention Program pursuant to sections 580-583 of Public Law 112-239. The directive also established the requirement for DoDSER submissions, analysis, and reporting.

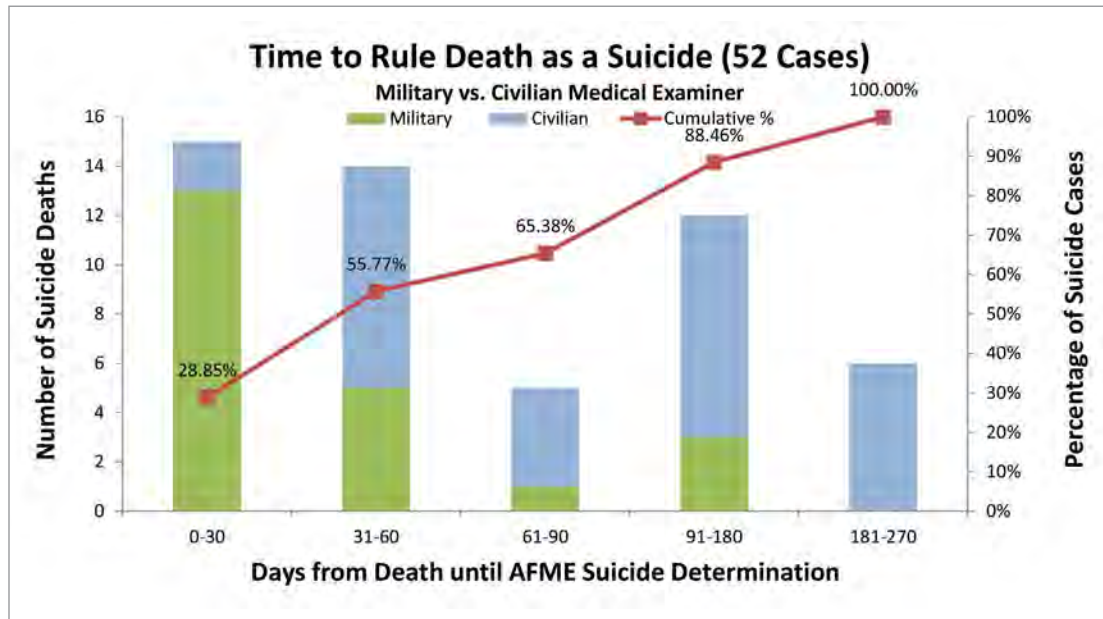
Background

DoD policy requires DoDSER submissions to be completed within 60 days of the Armed Forces Medical Examiner (AFME) making the final determination that the death was a suicide.⁷ However, we found that some locations submit DoDSER data before the AFME determination has been made.

The following figure (Figure 4 on page 14) indicates how long it took from the time of death until the AFME determined the manner of death. We examined a sample of 52 suicide death cases and found that less than 30 percent of the suicide cases had been closed by the medical examiner within 30 days of the death. It took 180 days after the death for 88 percent to be closed, and 270 days after the death for all the cases to be completed. There will be more incomplete reports with “don’t know/data unavailable” responses if a DoDSER is submitted while the medical examiner investigation is still being conducted. This is part of the rationale behind the DoD requirement to complete the DoDSER submission after the medical examiner has ruled the death a suicide.

⁷ Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, Subject: Standardized Reporting of Department of Defense Suicides and Department of Defense Suicide Event Report (October 14, 2009).

Figure 4. Time to Rule Death as a Suicide



Source: DoD IG

Discussion

Some Service policies set DoDSER submission timelines that significantly varied from the DoD requirement. Army⁸ and Air Force⁹ policies were consistent with DoD policy. However, Navy policy stated that commands would submit a DoDSER “within 60 days of notification of death;”¹⁰ Marine Corps policy required the DoDSER “within 15 working days.”¹¹

Regardless of the Service policy, several personnel interviewed indicated that they often submitted DoDSER data shortly after a death. These individuals asserted that some information could be lost if DoDSER data collection were delayed until after AFME issued the final ruling on the manner of death. They stated that information on work-related stress, relationship issues, or financial issues may not be accurate if they waited 6 to 9 months (for AFME final ruling on manner of death) to gather the information. The personnel also indicated that leadership transitions and unit deployments might hinder their ability to gather the information if they waited until the death determination had been made.

⁸ Army Medical Command Policy 13-037, “Policy Guidance for the Department of Defense Suicide Event Report (DoDSER) Program,” July 8, 2013, page 4.

⁹ Air Force Instruction 90-505, “Suicide Prevention Program,” August 10, 2012, page 6.

¹⁰ Chief of Naval Operations Instruction 1720.4A, “Suicide Prevention Program,” August 4, 2009, page 5.

¹¹ Marine Corps Order 1720 .2, “Marine Corps Suicide Prevention Program (MCSP),” April 10, 2012, page 9.

Finally, due to regulatory requirements, the DoDSER software automatically archived a record 180 days after being initiated in DoDSER. It is impossible to reopen or update a submission once a record is archived. In order to prevent having to re-create a DoDSER record, some individuals finalized a submission before the medical examiner investigation was complete and all relevant information was available.

Given these factors, some responsible personnel believed it was more important to submit the DoDSER early rather than wait for the final determination on the manner of death from the medical examiner.

Conclusion

While it is important to gather information early as part of the DoDSER investigation, it is equally important to wait until the medical examiner's death investigation has been completed before finalizing the DoDSER submission. As expressed in an interview during a site visit, "rushing to failure" with early DoDSER submissions will result in incomplete and/or inaccurate DoDSER data.

Given the unique nature of suicide death investigations and the operational requirements of many military units, it may not be possible to meet DoD standards for every DoDSER submission. Therefore, senior military leaders should have the ability to authorize extensions on a case-by-case basis.

Incomplete and/or inaccurate DoDSER data prevents detailed analysis of suicide risk factors and limits senior leaders and policy makers' ability to make informed decisions on suicide prevention and intervention programs.

Recommendations, Management Comments, and Our Response

Recommendation 1.a

Under Secretary of Defense for Personnel and Readiness publish guidance on the Department of Defense Suicide Event Report submission process to require:

- 1. initiating Department of Defense Suicide Event Reports within 30 days of suspected suicide death,**
- 2. completing Department of Defense Suicide Event Report submission no earlier than the Armed Forces Medical Examiner determination that the death was a result of suicide and no later than 60 days after the Armed Forces Medical Examiner determination,**

3. **allowing the first Flag/General Officer in a chain of command to authorize an extension for an additional 60 days, and**
4. **eliminating the 180-day auto-archive requirement on open Department of Defense Suicide Event Report death records.**

Under Secretary of Defense for Personnel and Readiness Comments

The Principal Deputy, responding for the Under Secretary of Defense for Personnel and Readiness, concurred with this recommendation and stated they would publish guidance that will include the recommended timelines by January 2015. The Principal Deputy also stated that they are coordinating a change to the System of Records Notice to eliminate the 180-day auto-archive requirement.

Our Response

The comments from the Principal Deputy are responsive and no additional comments are required.

Recommendation 1.b

Chiefs of the Military Services update their policies to incorporate Recommendation 1.a.

Army Comments

The Office of the Deputy Chief of Staff G-1, responding for the Army Chief of Staff, concurred without comment.

Our Response

The response from the Army Deputy Chief of Staff G-1 partially addressed the recommendation. Although agreeing with the recommendation, the Army Deputy Chief of Staff G-1 did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Army after DoD has published its guidance for the Services, as indicated in the management comments to Recommendation 1a.

Navy Comments

The Office of Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N171), responding for the Chief of Naval Operations, concurred with the recommendations and provided comments. While they questioned how often premature submissions affected data completeness, they agreed Recommendation 1.a was a “good approach.”

The Navy also expressed concern about the timing for publication of the annual DoD Suicide Event Report.

Our Response

The comments from the Office of Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N171) are responsive and no additional comments are required.

The issue of annual report timelines is outside the scope of this assessment. It is a topic for the Services and DoD to consider and discuss.

Air Force Comments

The Assistant Surgeon General for Health Care Operations, responding for the Air Force Chief of Staff, concurred with the recommendations and described how they would implement the recommendations using the Air Force's Community Action Board/Integrated Delivery System process.

Our Response

The comments from the Assistant Surgeon General for Health Care Operations are responsive and no additional comments are required.

Marine Corps Comments

The Marine and Family Programs Division, responding for the Commandant of the Marine Corps, concurred without comment.

Our Response

The response from the Marine and Family Programs Division partially addressed the recommendation. Although agreeing with the recommendation, the Marine and Family Programs Division did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Marine Corps after DoD has published its guidance for the Services, as indicated in the management comments to Recommendation 1a.



Observation 2

DoDSER Data Collection is Stovepiped

DoDSERs did not consistently include highly relevant information from other sources such as medical records, law enforcement investigations, or command investigations, that would provide a better understanding of the circumstances and stressors related to suicidal behavior.

DoD policy did not require a multidisciplinary approach to gathering DoDSER data.

DoDSER accuracy suffered from a high number of “don’t know/data unavailable” responses because of a lack of awareness of other sources of information and/or a failure to share this information with those preparing the report.

Applicable Criteria

DoD Directive 6490.14 established the policy for the Defense Suicide Prevention Program pursuant to sections 580-583 of Public Law 112-239. The directive also established the requirement for DoDSER submissions, analysis, and reporting.

Background

This DoD policy required the Secretaries of the Military Departments to “provide guidance for the collection of suicidal self-directed violence data” and to “(d)esignate trained personnel to complete a DoDSER entry for all confirmed suicides.”¹²

Data gathered by the National Center for Telehealth and Technology indicated that higher quality DoDSER submissions used multiple sources of data to complete the DoDSER. High quality DoDSER submissions (missing less than 25 percent of the required information) often used at least three different sources of data. These most frequently included medical records, personnel records, manner of death investigations, and law enforcement investigations. In comparison, DoDSER submissions with the highest number of “don’t know/data unavailable” items typically used only one source of data. Table 4 on page 20 provides details.

¹² DoD Directive 6490.14 p. 8 and 9.

Table 4: Sources of Supporting Documentation for CY 2011 DoDSER Submissions (n=287)

Source of DoDSER Supporting Information	DoDSER Submissions with 25% or less data unavailable (161 cases)	DoDSER Submissions with 25% - 50% data unavailable (55 cases)	DoDSER Submissions with 50% - 75% data unavailable (43 cases)	DoDSER Submissions with 75% or more data unavailable (28 cases)
	Percentage of DoDSER Submissions that Used the Source			
Medical Records	85	76	84	50
Family Advocacy	10	13	9	4
Substance Abuse Program	6	6	12	0
Personnel Records	63	38	14	14
Law Enforcement Investigation	41	29	7	0
Court-Martial Records	3	0	0	0
Medical Examiner Reports	55	36	26	18
Median Number of Sources Used	3	2	1	1

Source: National Center for Telehealth & Technology

Discussion

During many of the site visits, several DoDSER submitters acknowledged they used only one or two sources of information. Several DoDSER submitters admitted they did not know how to request law enforcement investigations or other records from community-based support services. Typically, the DoDSER submitter would use the source of information most closely aligned with their normal duty assignment. For example, a DoDSER submitter who worked in the military treatment facility used medical records; a DoDSER submitter from the unit chain of command typically used the command investigation.

“The Army has already collected this information, let’s let the investigator report it and let me use that.”

DoDSER Submitter

Conclusions

A multidisciplinary approach to gathering information yielded more complete DoDSER results. Unit leadership, supporting medical and mental health professionals, installation law enforcement personnel, and community support personnel each provide a unique perspective that adds to the completeness of the DoDSER submission. A suicide event board would be similar to the multidisciplinary fatality review team that is effectively used in DoD for other death investigations¹³ (motorcycle accidents, domestic violence, etc.). The suicide event board would help reduce the number of DoDSER “don’t know/data unavailable” responses and improve the usefulness of DoDSER data gathered after suicide deaths.

Recommendations, Management Comments, and Our Response

Recommendation 2.a

Under Secretary of Defense for Personnel and Readiness publish guidance requiring suicide event boards to establish a multidisciplinary approach for obtaining the data necessary to make comprehensive Department of Defense Suicide Event Report submissions. For each suicide death this board should:

- 1. be a locally (command or installation level) chartered board with defined task, purpose, and outcome for each suicide death review,**
- 2. include participation by unit leadership, medical/mental health, and Military Criminal Investigative Organizations, and**
- 3. articulate the requirement to appropriately share information (for example, medical and law enforcement reports) from ongoing investigations.**

Under Secretary of Defense for Personnel and Readiness Comments

The Principal Deputy, responding for the Under Secretary of Defense for Personnel and Readiness, concurred with this recommendation and stated they would draft guidance for coordination by April 2015.

Our Response

The comments from the Principal Deputy are responsive and no additional comments are required.

¹³ The construct of a multidisciplinary review team or suicide event board is based on the fatality review team from DoDI 6400.06. This multidisciplinary team requires training and review procedures to standardize the analysis and reporting of suspected domestic violence deaths.

Recommendation 2.b

Chiefs of the Military Services update their policies to incorporate Recommendation 2.a.

Army Comments

The Office of the Deputy Chief of Staff G-1, responding for the Army Chief of Staff, concurred without comment.

Our Response

The response from the Army Deputy Chief of Staff G-1 partially addressed the recommendation. Although agreeing with the recommendation, the Army Deputy Chief of Staff G-1 did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Army after DoD has published its guidance for the Services, as indicated in the management comments to Recommendation 2a.

Navy Comments

The Office of Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N171), responding for the Chief of Naval Operations, concurred with the recommendations and provided comments. The Navy requested Recommendation 2.a. be changed to include, "This board should be convened as soon as possible once AFME has confirmed the death as suicide."

Our Response

The comments from the Navy N171 are responsive and no additional comments are required. We considered the Navy's request to change the recommendation, but we did not act on their request because it was outside the scope of this observation. We defer to the Under Secretary of Defense for Personnel and Readiness and the Services to develop appropriate implementing guidance for when and how a suicide event board would convene. As discussed in Observation 1, we encourage the implementing guidance to assign responsibilities and gather perishable information shortly after the death. Additionally, the guidance should finalize the DoD Suicide Event Report submission after the Armed Forces Medical Examiner has made the final determination on the manner of death.

Air Force Comments

The Assistant Surgeon General for Health Care Operations, responding for the Air Force Chief of Staff, concurred with the recommendations and described how they would implement the recommendations at the installation level by using the suicide prevention program manager to lead the suicide event board process.

Our Response

The comments from the Assistant Surgeon General for Health Care Operations are responsive and no additional comments are required.

Marine Corps Comments

The Marine and Family Programs Division, responding for the Commandant of the Marine Corps, concurred without comment.

Our Response

The response from the Marine and Family Programs Division partially addressed the recommendation. Although agreeing with the recommendation, the Marine and Family Programs Division did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Marine Corps after DoD has published its guidance for the Services, as indicated in the management comments to Recommendation 2a.



Observation 3

Insufficient Information to Answer Technical Questions

Many DoDSER questions could not be answered precisely or accurately because they contained technical medical language that required subject matter expertise to answer.

The qualifications/background of those submitting DoDSER data varied significantly, from well-versed experts to unit leaders submitting their first (and possibly, only) DoDSER. DoDSER submitters do not always consult subject matter experts to obtain accurate answers to technical questions.

Some individuals selected “don’t know/data unavailable” because they did not understand the DoDSER question or did not believe they had the expertise to respond.

Discussion

The background, training, and experience of personnel submitting DoDSERs varied significantly. Our assessment found that the background of DoDSER submitters ranged from clinical psychologists with more than 20 years of experience to subsurface sonar technicians who had never submitted a DoDSER. Regardless of background and experience, DoDSER submitters encountered questions they could not answer.

For example, some healthcare professionals encountered DoDSER questions they could not answer, but unit leadership would have been able to address. The DoDSER question on participation in the Personnel Reliability Program (PRP) at the time of the suicide event was the fifth highest “don’t know/data unavailable” question in 2011. The PRP is a screening program for individuals who work with exceptionally sensitive and/or classified programs. Commanders are responsible for identifying who belongs in the PRP based on their duty responsibilities. It would be impossible for a service member to be in the PRP without their chain of command’s knowledge. Nonetheless, several of the people interviewed for this assessment acknowledged they checked “don’t know/data unavailable” because they were not familiar with the PRP.

“I always check ‘don’t know’ to that question because I don’t know what that program is.”

DoDSER Submitter

Conversely, the chain of command responsible for submitting DoDSER (who understand PRP) information sometimes encountered questions they did not understand, but that subject matter experts would have been able to answer. For example, a Senior Chief Sonar Technician¹⁴ responsible for a DoDSER submission lacked the expertise to ascertain if a service member had been diagnosed with a psychotic or other mental health disorder. Such questions require medical subject matter expertise to interpret and accurately answer.

The DoDSER question concerning a service member's "family history of mental illness" also generated a high number of "don't know/data unavailable" responses. Some individuals interviewed indicated that they checked "don't know" if they were unable to interview family members (parents, siblings, aunts, uncles, etc.). If a family history was not mentioned in the medical record, these submitters indicated "don't know" on the DoDSER because there was no data to support a conclusive "yes" or "no" response.

Conclusions

DoDSER questions should be clear, unambiguous, and definitive. DoDSER questions need to have the specificity required to answer detailed research questions. For example, questions on mental health or substance abuse diagnoses may require direction on the service professional that may be best positioned to address those items.

DoDSER submitters need to know who to ask for additional guidance about the intent and purpose of specific questions. Adopting a multidisciplinary suicide event board approach to DoDSER submissions (described in Observation 2 and Recommendation 2.a) will expand the pool of subject matter experts at the local level who can research and respond to specific medical, legal, or military service questions. These subject matter experts would use existing information (for example, medical and substance abuse treatment records, or law enforcement investigations) to answer DoDSER questions.

Finally, establishing a suicide event board will ensure leadership is involved in the DoDSER submission. Leadership involvement can improve the accountability for DoDSER submitters to have accurate information.

¹⁴ This Senior Chief Sonar Technician was given the additional duty for submitting a DoDSER. This was his first and only DoDSER submission.

Recommendations, Management Comments, and Our Response

Recommendation 3.a

Under Secretary of Defense for Personnel and Readiness, in accordance with Recommendation 2.a, publish guidance requiring a suicide event board to enable a multidisciplinary approach for obtaining the data required to make a comprehensive Department of Defense Suicide Event Report submission.

Under Secretary of Defense for Personnel and Readiness Comments

The Principal Deputy, responding for the Under Secretary of Defense for Personnel and Readiness, concurred with this recommendation and stated they would publish guidance on establishing suicide event boards by April 2015.

Our Response

The comments from the Principal Deputy are responsive and no additional comments are required.

Recommendation 3.b

Director, National Center for Telehealth & Technology modify the Department of Defense Suicide Event Report software to:

- 1. allow some Department of Defense Suicide Event Report responses to be “No Known History of XXX,”**
- 2. modify some Department of Defense Suicide Event Report responses to require an explanation/justification for any “don’t know/data unavailable” response, and**
- 3. refine user/technical assistance into the Web-based Department of Defense Suicide Event Report submission forms (pop-up help with instructions and possible sources of information [for example, medical record, Military Criminal Investigative Organization, personnel file]).**

Director, National Center for Telehealth & Technology Comments

The Chief of Staff for the Army Surgeon General, responding for the Director, National Center for Telehealth & Technology, concurred with this recommendation and anticipates implementing the software changes in January 2016.

Our Response

The comments from the Chief of Staff for the Army Surgeon General are responsive and no additional comments are required.

Recommendation 3.c

Director, National Center for Telehealth & Technology conduct after action reviews of selected Department of Defense Suicide Event Report submissions directly with submitters in order to identify what they perceived as confusing questions.

Director, National Center for Telehealth & Technology Comments

The Chief of Staff for the Army Surgeon General, responding for the Director, National Center for Telehealth & Technology, concurred with this recommendation and stated they would develop and implement a plan to conduct after action reviews by January 2015.

Our Response

The comments from the Chief of Staff for the Army Surgeon General are responsive and no additional comments are required.

Recommendation 3.d

Chiefs of the Military Services update guidance to:

- 1. identify subject matter experts to provide Department of Defense Suicide Event Report tech support to address questions, and**
- 2. adapt and implement the proposed standard operating procedure/ guidelines for Department of Defense Suicide Event Report submission process (see Appendix C) to help Department of Defense Suicide Event Report submitters understand the various sources of information (for example, military law enforcement and medical) needed to submit a complete Department of Defense Suicide Event Report.**

Army Comments

The Office of the Deputy Chief of Staff G-1, responding for the Army Chief of Staff, concurred without comment.

Navy Comments

The Office of Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N171), responding for the Chief of Naval Operations, concurred without comment.

Air Force Comments

The Assistant Surgeon General for Health Care Operations, responding for the Air Force Chief of Staff, concurred without comment.

Marine Corps Comments

The Marine and Family Programs Division, responding for the Commandant of the Marine Corps, concurred without comment.

Our Response

The response from the Services partially addressed the recommendation. Although agreeing with the recommendation, none of the Services provided any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Chiefs of the Military Services after DoD has published its guidance for the Services, as indicated in the management comments to Recommendation 3a.



Observation 4

Limited User Feedback and Empowerment

DoDSER submissions were viewed by the Services as a separate DoD requirement and therefore were not integrated into Service suicide prevention reporting and lessons learned processes.

The Services had not integrated DoDSER data collection into their suicide prevention reporting and lessons learned analysis processes.

- Commanders and organizations considered DoDSER submissions as an additional duty rather than a primary mission.
- Commanders did not have the ability to generate relevant command-level reports from DoDSER data.
- Medical manpower/workload accounting did not enable military treatment facilities to appropriately take credit for the level of effort required to support DoDSER data collection and submission. This workload was considered overhead rather than suicide prevention activities.

DoDSER accuracy and completeness suffered from a high number of “don’t know/data unavailable” responses because DoDSER submissions did not reflect information obtained during Service suicide prevention lessons learned processes.

Discussion

The ability to generate DoDSER on-demand¹⁵ reports is restricted to the Service or major command level, therefore most commands and installations have to request a historical or trend report from higher-level headquarters. The withholding of information by higher-level headquarters limited the ability of a unit to do its own trend analysis and to compare itself to similar organizations. As a result, five of the six organizations we visited had to maintain their own version of a “shadow”¹⁶ DoDSER to track trends.

“I’m fascinated by whatever my commander is interested in . . . he hasn’t mentioned DoDSER.”

DoDSER Submitter

¹⁵ On-demand reports, provided in response to a commander’s request, afford similar information to what is provided in the annual reports, but reflect a subset of information most relevant to the local commanders. Having similar reports produced at the local level would allow leaders to track trends in a timely manner.

¹⁶ Duplicate spreadsheet or database maintained at the unit or installation.

The Services have established processes for gathering suicide prevention lessons learned. Those processes involved unit leadership collecting information, and reporting to senior Service leadership. These processes reflected the importance the Services placed on suicide prevention.

However, none of the Services included DoDSER data collection as part of their Service lessons learned process, despite the overlapping data requirements. The Service lessons learned processes frequently reported the role alcohol or prescription medication may have played in a suicide, yet these questions were in the top 10 of the “don’t know/data unavailable” DoDSER items.

Medical Workload Accounting

Workload in all Services’ medical treatment facilities is tracked using the Medical Expense and Performance Reporting System (MEPRS). Manpower and budget programming is largely dependent on accurately documenting work via MEPRS. For example, Army MEPRS tracks three behavioral health promotion and training workload tasks:

- Behavioral Health Prevention – external (outside the medical treatment facility) prevention and promotion training,
- Sexual Assault – external group training, and
- Care Provider Support Program – education and training of medical treatment facility personnel on the signs and symptoms of compassion fatigue.

None of these MEPRS categories account for time spent in support of submitting data into DoDSER. Therefore, the time spent supporting DoDSER activities is not tracked as patient care workload; it is reported as overhead.

Conclusions

It is important for the individuals who submit DoDSER information to understand the value of that work to their Service and to DoD. If local commanders are not able to use the DoDSER information to produce standardized reports or conduct other trend analyses, they may duplicate that effort by creating “shadow” data systems. The DoDSER submitters we interviewed frequently viewed DoDSER as a separate requirement outside their Service’s lessons learned processes.

Medical personnel were not receiving appropriate workload credit for DoDSER submissions, important suicide prevention work. Grouping DoDSER work into a larger overhead activity diminished the importance of DoDSER submissions, and created a disincentive to expend the effort necessary to submit a complete and accurate DoDSER.

Finally, organizations and units tend to do well those things that senior leaders prioritize and check. Having a method to review a sample of DoDSER submissions and providing feedback on those submissions would help the Services improve their processes. This command attention would ensure the integration of DoDSER and Service lessons learned processes, and allow maximum benefit to leaders and policymakers.

Recommendations, Management Comments, and Our Response

Recommendation 4.a

Under Secretary of Defense for Personnel and Readiness authorize senior commanders to produce unit/installation reports to better understand suicide trends, make informed local suicide prevention policy, and relate their trends to Service and DoD trends.

Under Secretary of Defense for Personnel and Readiness Comments

The Principal Deputy, responding for the Under Secretary of Defense for Personnel and Readiness, concurred with this recommendation and stated they would draft guidance by April 2015. The Principal Deputy emphasized that implementation “must address privacy concerns, especially with regard to non-fatal suicide attempts.”

Our Response

The comments from the Principal Deputy are responsive and no additional comments are required.

Recommendation 4.b

Director, Defense Health Agency update policy to recognize manpower credit expended for Department of Defense Suicide Event Report workload in the Medical Expense and Performance Reporting System.

Director, Defense Health Agency Comments

The Principal Deputy for the Under Secretary of Defense for Personnel and Readiness, responding for the Director of the Defense Health Agency, concurred with comments to this recommendation. While noting that the Medical Expense and Performance Reporting System was a cost accounting and not a workload reporting system, the Principal Deputy stated that the “Defense Health Agency

MEPRS Program Office would work through the Services' MEPRS Program Office points of contact to clarify, determine, and standardize in which MEPRS Special Program summary and sub-account the DODSER labor hours will be reported." The Principal Deputy estimated they could complete developing a standardized approach for recording DODSER hours within in six months from the date of this report.

Our Response

The comments from the Principal Deputy are responsive and no additional comments are required.

Recommendation 4.c

Director, National Center for Telehealth & Technology, upon receipt of authority resulting from Recommendation 4.a, update software to allow unit/installation trend reports.

Director, National Center for Telehealth & Technology Comments

The Chief of Staff for the Army Surgeon General, responding for the Director, National Center for Telehealth & Technology, concurred with this recommendation stating that they would update the software to allow unit/installation trend reports and ensure a unified approach to analyze and standardize data after they receive approval and authority from Under Secretary of Defense for Personnel and Readiness and the Defense Health Agency.

Our Response

The comments from the Chief of Staff for the Army Surgeon General are responsive and no additional comments are required.

Recommendation 4.d

Director, National Center for Telehealth & Technology perform annual independent quality assurance reviews of a representative sample of Department of Defense Suicide Event Report submissions to identify opportunities for improving data quality.

Director, National Center for Telehealth & Technology Comments

The Chief of Staff for the Army Surgeon General, responding for the Director, National Center for Telehealth & Technology, concurred with this recommendation and stated they would "develop a plan to conduct annual independent reviews to identify opportunities for improve data quality." They anticipate conducting the first review by December 2015.

Our Response

The comments from the Chief of Staff for the Army Surgeon General are responsive and no additional comments are required.

Recommendation 4.e

Chiefs of the Military Services update policies to integrate Department of Defense Suicide Event Report data collection and submission practices into their Service suicide prevention lessons learned processes.

Army Comments

The Office of the Deputy Chief of Staff G-1, responding for the Army Chief of Staff, concurred without comment to the draft report.

Our Response

The response from the Army Deputy Chief of Staff G-1 partially addressed the recommendation. Although agreeing with the recommendation, the Army Deputy Chief of Staff G-1 did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Army.

Navy Comments

The Office of Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N171), responding for the Chief of Naval Operations, concurred with the recommendations and provided comments. They expressed concern about non-subject matter experts “performing trend analysis or comparing raw data to make conclusions.” They also stated that the “Navy does include DoDSER data collection as part of our Service lessons learned (about Navy suicides) process....”

Our Response

The comments from the Office of Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N171) partially addressed the recommendation. Although agreeing with the recommendation, the DCNO (N171) did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Navy.

We defer to the Navy to determine what command level is most appropriate for conducting trend analysis. However, we observed commands conducting trend analysis without access to DoDSER data. Therefore, we encourage the Navy to consider developing methods to meet the commands’ needs in a timely manner.

Air Force Comments

The Assistant Surgeon General for Health Care Operations, responding for the Air Force Chief of Staff, concurred with the recommendations. They stated the implementation of these recommendations “would work at the MAJCOM [Major Command] level where the incidence numbers of suicide attempts and suicides approach the level that would lend them to trend analysis.”

Our Response

The comments from the Assistant Surgeon General for Health Care Operations are responsive and no additional comments are required.

Marine Corps Comments

The Marine and Family Programs Division, responding for the Commandant of the Marine Corps, concurred without comment to the draft report.

Our Response

The response from the Marine and Family Programs Division partially addressed the recommendation. Although agreeing with the recommendation, the Marine and Family Programs Division did not provide any further information on implementation or an anticipated timeline. The Office of the Inspector General will follow-up with the Marine Corps.

Observation 5

Military Crisis Line Lacks Access to Relevant Service Member Information

The Veterans/Military Crisis Line staff was unable to conduct in-depth assessments and provide necessary assistance to service members who called the Crisis Line to the same degree as they did for veterans receiving Department of Veterans Affairs (VA) treatment and whose medical records were available to the Crisis Line staff.

This occurred because Veterans/Military Crisis Line staff did not have access to military personnel medical records or other relevant military healthcare information.

As a result, service members who called the Veterans/Military Crisis Line were at increased risk of not receiving the required suicide crisis intervention. Lack of access to military medical records also degraded the VA's ability to coordinate follow-up care through the Military Health System.

Applicable Criteria

Section 1635 of Public Law 110-181, The National Defense Authorization Act (NDAA) for Fiscal Year 2008, states, "Secretary of Defense and the Secretary of Veterans Affairs shall jointly accelerate the exchange of health care information between the Department of Defense and the Department of Veterans Affairs in order to support the delivery of health care by both Departments."

Background

Since its creation in 2007, the VA's Veterans/Military Crisis Line has been the primary crisis hotline for not only veterans and former service members; but for active, Reserve, and retired service members as well. In FY 2012, over 2,500 service members (both active and Reserve) called the Crisis Line. In FY 2013, more than 3,300 service members called the Crisis Line.

The DoD IG's DoDSER assessment team met with VA staff members at the VA's National Suicide Prevention Center of Excellence and Veterans National Crisis Line in Canandaigua, New York. The purpose of this visit was to identify possible VA best practices applicable to DoDSER.

However, during this site visit, VA staff indicated they did not have access to military-service healthcare/medical record information like they do for veterans who are receiving medical care from the VA. Access to medical record information allows the VA to conduct meaningful, timely suicide risk assessments when someone calls the Crisis Line. VA Crisis Line staff is unable to provide the same level of risk assessment for service members as they provide to veterans because they do not have access to military-service medical records.

Crisis Line staff also discussed the challenge of subsequently referring service members to military mental health or other appropriate medical care. The Crisis Line staff could not provide the same level of coordinated medical care for service members as they delivered to veterans in the Veterans Health Administration.

“Whenever Veterans are identified as surviving an attempt or are otherwise identified as being at high risk, they are placed on the facility high-risk list and their chart is flagged such that local providers are alerted to the suicide risk”

Dr. Kemp, VA¹

¹ House Committee on Veterans’ Affairs, Hearing on 12/02/2011: Understanding and Preventing Veteran Suicide, Witness Testimony of Jan E. Kemp, RN, Ph.D., National Mental Health Director for Suicide Prevention, Veterans Health Administration, U.S. Department of Veterans Affairs.

Discussion

The Veterans/Military Crisis Line staff had no visibility of a service member’s past suicide history. They had no information on medical or mental health history. They had no knowledge of prescription medications. In effect, the Crisis Line staff lacked awareness of many of the healthcare related risk factors for suicide and had to rely on service member self-reporting to conduct a risk assessment.

Knowing medical suicide risk factors is critical for Crisis Line personnel to conduct a risk assessment and to make decisions related to appropriate intervention. Without this healthcare information, the service member is at an increased risk of not receiving appropriate, timely referrals to mental health or medical treatment.

The requirement for medical information sharing is jointly shared by DoD and VA. There may be Reserve Component service members who receive mental health care from the VA while they are in a non-active duty status. The VA should inform DoD when a service member has been treated for a service-related injury or illness, including the medications prescribed to the service member, by VA. This is necessary so that DoD can improve continuity of care if the service member subsequently serves on active duty.

Conclusions

For the Veterans/Military Crisis Line to be effective in providing necessary, and often immediately required assistance, Crisis Line personnel should have access to all relevant information pertaining to suicide-related history, mental health treatment, prescription medications, and other relevant medical information (excluding DoDSER or other public health surveillance data). Access to this information could prove vital in saving a service member's life.

DoD's Military Health System needs to know about treatment for medical and mental health issues that the VA provides to Reserve Component service members when they are not on active duty.

DoD sharing protected health information with the VA may require changes to System of Record Notifications (SORN).¹⁷

According to the Defense Health Agency, neither the Privacy Act of 1974 nor the Health Insurance Portability and Accountability Act of 1996, prohibit the sharing of relevant healthcare information between DoD and VA. This is further reinforced by the FY 2008 NDAA that required DoD and VA to "accelerate the exchange of health care information."

Recommendations, Management Comments, and Our Response

Recommendation 5

Director, Defense Health Agency improve data sharing of healthcare information with the VA by:

- a. identifying the relevant data sources that would enable improved understanding of service members' medical conditions and prior treatments when they call the Veterans/Military Crisis Line, and update the appropriate System of Record Notifications to allow for sharing of relevant DoD clinical data with the Military Crisis Line,**
- b. developing a process for Veterans/Military Crisis Line staff to refer service members back to the Military Health System or other appropriate medical care to improve continuity of care by ensuring the Military Health System is informed of crisis care provided, and**
- c. coordinating with the Veterans Affairs to ensure policies are established to appropriately manage privacy issues.**

¹⁷ A System of Record Notifications is a formal notice published in the Federal Register that identifies the purpose for collecting personally identifiable information or protected health information.

Director, Defense Health Agency Comments

The Principal Deputy for the Under Secretary of Defense for Personnel and Readiness, responding for the Director of the Defense Health Agency, concurred with comments to this recommendation. The Principal Deputy stated that the “recommendation is premature, and that facilitating improvement requires careful consideration of broader questions to develop a holistic approach to improve performance where needed.” She stated that DoD will conduct a review.

Our Response

The comments from the Principal Deputy for the Under Secretary of Defense for Personnel and Readiness did not address the specifics of the recommendation. Although the Principal Deputy concurred with this recommendation, no plan or timeline for sharing relevant data with the Military Crisis Line was provided.

This observation and recommendation was brought to the attention of senior leadership in the Defense Health Agency on January 27, 2014. It was also briefed to senior leadership in the Office of the Under Secretary of Defense for Personnel and Readiness on April 18, 2014.

We identified this as a particularly serious suicide prevention issue that requires action. Therefore, additional comments are required that describe the specific actions the Defense Health Agency will take to accomplish this recommendation. These comments should include the completion date for these actions.

Observation 6

DoDSER Data is Not Shared with the VA

DoDSER data was not shared with VA for integration into their suicide surveillance database.

The System of Record Notification limits DoDSER data sharing and has prevented DoD from establishing a routine transfer of relevant information to the VA.

The VA is not able to use comprehensive health surveillance data collected by DoD to better understand how military service experience (deployment history, previous suicide attempts, etc.) impacts post-service suicidal behavior.

Applicable Criteria

Section 1635 of Public Law 110-181 states, “Secretary of Defense and the Secretary of Veterans Affairs shall jointly accelerate the exchange of health care information between the Department of Defense and the Department of Veterans Affairs in order to support the delivery of health care by both Departments.”

DoD Directive 6490.02E, “Comprehensive Health Surveillance,” February 8, 2012 states “(c)omprehensive health surveillance is an important element of force health protection (FHP) programs to promote, protect, and restore the physical and mental health of DoD personnel throughout their military service and employment, both in garrison and during deployment.”

Background

The recent increased rate of service member and veteran suicide deaths has been of significant interest to DoD leaders and Congress. Veterans are thought to be at greater risk for suicide than the general population. In 2007, Dr. Mark S. Kaplan reported in the Journal of Epidemiology and Community Health that male veterans are at twice the risk for suicide as their non-veteran counterparts. The VA estimated that 22 veterans died by suicide every day in CY 2010. Access to information pertaining to a service member’s relevant military experience, including past mental health treatment, is critical to improving suicide prevention and intervention.

DoDD 6490.02E requires that health surveillance data collected on individuals by DoD be provided to VA when a service member separates from the Service. The directive also allows DoD and VA to specifically request and agree on data transfer at other times.

The DoDSER SORN states it is to be used “for direct reporting of suicide events and ongoing population-based health surveillance activities.” DoDSER data is collected on “individuals with reportable suicide and self-harm behaviors.” Statistical summary data (with no personally identifiable information) may be provided to authorized personnel for the purpose of health surveillance and research, but individual records are not typically disclosed.

Discussion

Suicide surveillance is a critical component of VA’s suicide prevention strategy. VA required the tracking of suicide attempts and deaths in a standardized national database, the Suicide Prevention and Application Network (SPAN). SPAN and DoDSER are the “nation’s only real-time suicide surveillance systems.”¹⁸

“There is a need to promote the development of local reports on suicide and suicide attempts and to integrate data from multiple data management systems.”

National Strategy for Suicide Prevention

One of the key indicators for future suicide behavior is a history of previous suicide attempts. Therefore, researchers have emphasized the importance of improving our understanding of “when, where, and among whom suicidal behavior occurs.”¹⁹

Conclusion

Section 1635 of Public Law 110-181 mandates the accelerated exchange of healthcare information between DoD and VA. Sharing DoDSER data with VA would substantially enhance VA’s ability to develop and maintain key military service and medical history information on recently separated and retired service members and Reserve/National Guard service members. Without appropriate medical history, VA cannot develop its own comprehensive outreach and prevention programs for former service members who may be at increased risk for suicide.

DoDD 6490.02E requires the transfer of health surveillance data to VA, at a minimum, when service members separate or retire from the Service. DoDSER is the health surveillance system that gathers data for the purpose of analyzing, interpreting, and reporting on suicide behaviors. Therefore, DoDSER data should be shared with VA.

¹⁸ *Suicide Data Report*, 2012, Department of Veterans Affairs, undated, page 26.

¹⁹ Dr. Matthew Nock, *Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors*, Psychiatry 76(2) Summer 2013, page 97.

Recommendations, Management Comments, and Our Response

Recommendation 6

Director, Defense Health Agency:

- a. update appropriate System of Record Notification to allow for sharing of DoD Suicide Event Report data with the Department of Veterans Affairs to enable health surveillance, as required by DoDD 6490.02E.**
- b. coordinate with Department of Veterans Affairs to ensure appropriate policies are established to manage privacy issues while sharing Department of Defense Suicide Event Report data.**

Director, Defense Health Agency Comments

The Principal Deputy for the Under Secretary of Defense for Personnel and Readiness, responding for the Director of the Defense Health Agency, concurred with this recommendation.

Our Response

The comments from the Principal Deputy for the Under Secretary of Defense for Personnel and Readiness partially addressed the recommendation. Although the Principal Deputy concurred with this recommendation, no implementation plan or timeline was provided.

Additional comments are required that describe the specific actions the Defense Health Agency will take to accomplish this recommendation. These comments should include the completion date for these actions.



Observation 7

Inconsistent Military Criminal Investigative Organizations Participation in DoDSER Process

DoDSER submitters rarely obtained information from the Military Criminal Investigative Organizations (MCIO) or collateral civilian investigation (death investigations when a civilian law enforcement agency has primary responsibility). Information obtained from the death investigation would have decreased the number of “don’t know/data unavailable” responses.

DoD policy did not specifically request MCIO participation in a multidisciplinary approach to gathering DoDSER data.

DoDSER annual reports may not fully reflect all military suicide risk factors and death investigation details because law enforcement investigations were not consistently used to substantiate relevant DoDSER data fields. Therefore, DoD policymakers and senior leaders (using DoDSER annual reports) were not fully informed on relevant military suicide risk factors.

Applicable Criteria

DoD Instruction 5505.10, “Criminal Investigations of Noncombat Deaths,” August 15, 2013, implements policy for investigating noncombat deaths of active duty service members as required by section 113 of title 10, United States Code (10 U.S.C. § 113 [2012]).

DoD Directive 6490.14 established the policy for the Defense Suicide Prevention Program pursuant to sections 580-583 of Public Law 112-239. The directive also established the requirement for submission, analysis, and reporting of DoDSER data.

Discussion

Many suicide deaths happen off a military installation (off-post) and outside of the investigative jurisdiction of military law enforcement organizations. Off-post suicide deaths are typically investigated exclusively by civilian law enforcement and medical examiner agencies, and only occasionally, do MCIO’s assist in their investigations. A civilian medical examiner or coroner usually conducts the autopsy for off-post investigations.

The following table (Table 5) indicates the location of death and the investigative source (civilian law enforcement (LE) or military law enforcement) for the 80 suicide death investigations reviewed during this assessment. It also displays who conducted the autopsy (civilian or military medical examiner/coroner). A total of 73 percent of suicide deaths we reviewed occurred off-post (58 of 80), and 48 percent of suicide deaths had a civilian autopsy (38 of 80).

Table 5. Location of Death and Autopsy Source

Autopsy Source	Location of Death & Investigation Source				Grand Total
	Off Post		On Post		
	Civilian LE*	Military LE	Civilian LE	Military LE	
Civilian ME**	36	1	0	1	38
Military ME	9	5	1	20	35
None	7	0	0	0	7
Grand Total	52	6	1	21	80

* LE = Law Enforcement ** ME = Medical Examiner

Source: DoD IG

MCIOs do not have jurisdiction to unilaterally investigate all suicide deaths of service members. DoD Instruction 5505.10 states, “the MCIO will maintain liaison with the law enforcement organization that is conducting the investigation.” It also indicates “[t]he MCIO will obtain and provide a copy of the investigation report to the appropriate military authorities, including any forensic or autopsy results.”

Civilian law enforcement organizations do not typically investigate military specific criminal offenses that may be relevant to suicide deaths. For both civilian and military law enforcement agencies, the primary purpose of a death investigation is to determine whether the death may have been caused by the criminal act of another. Only MCIOs have the additional responsibility to investigate Uniform Code of Military Justice (UCMJ) specific elements of criminal offenses connected with deaths.

MCIO death investigations can also address UCMJ violations such as Article 93 (cruelty and maltreatment of subordinates), Article 80 (attempts), and Article 134 (general article: all disorders and neglects to the prejudice of good order and discipline). Clarity with respect to whether these UCMJ violations occurred may also greatly enhance understanding of suicide risk factors in service members.

DoD Instruction 5505.10 states the scope of a death investigation will be sufficient to “[p]rovide information to support DoD and command programs relating to analysis and prevention of military deaths.” DoDSER data collection and submission process qualifies as one of these programs.

Air Force policy on “Criminal Investigations” specifically requires active participation in Event Review Board processes and explicitly authorizes appropriate information sharing in support of DoDSER data collection.

Army policy on “Criminal Investigation Operational Procedures” authorizes sharing of “investigative information with other investigators” (line of duty, command investigations, etc.) “to the maximum legal extent.”

Navy policy does not address information sharing with other investigators.

During team interviews with MCIO Headquarters’ leadership, they agreed their organizations could share investigative details, as long as there was not a negative impact on the death investigation. Further, MCIOs recognized this benefit and agreed their agents could attend the proposed Suicide Event Boards to facilitate a multidisciplinary approach to the DoDSER and fulfill the intent of DODI 5505.10.

Conclusions

It is not feasible for MCIOs to have the investigative lead for all off-post deaths, and DoD does not have the authority, nor jurisdiction, to influence civilian law enforcement organizations. However, MCIOs are already required to obtain a copy of the civilian investigation report and can be the primary point of contact for investigative information for the line of duty, command investigations, and Suicide Event Board processes. During the proposed Suicide Event Boards, the MCIO can determine if further investigation may be warranted by the MCIO into military specific crimes, contributing factors to the suicide, and/or if additional interviews are required that may be in the best interest of the Service.

“[M]edical examiners’ records are important sources of information and may contribute to our understanding of the extent of suicide in a population and associated socio-demographic and other factors.”

Chronic Diseases and Injuries in Canada, September 2011

While DoD policy encourages sharing of investigative information to support prevention programs, the variance in Service policies may be interpreted in such a way to create unintentional barriers to timely sharing of relevant death investigation information with DoDSER submitters. The authority provided in DoD Instruction 5505.10 to support analysis for preventing military deaths already addresses and encourages MCIOs to participate in command programs (for example, DoDSER data collection or proposed Suicide Event Boards).

Recommendations, Management Comments, and Our Response

Recommendation 7

Commanding General United States Army Criminal Investigation Command, Director of the Naval Criminal Investigative Service, and Commander, Air Force Office of Special Investigations update policy to specifically encourage Military Criminal Investigative Organization participation in the Department of Defense Suicide Event Report submission process, as well as in the proposed Suicide Event Boards (Recommendation 2.a), given available resources and the circumstances of each case, per DoD Instruction 5505.10 guidance.

Army Criminal Investigation Command Comments

The Army Criminal Investigation Command concurred with the recommendation to the draft report and published guidance.

Our Response

The comments from the Army Criminal Investigation Command are responsive and no additional comments are required.

Naval Criminal Investigative Service Comments

The Navy Criminal Investigative Service concurred with the recommendation and stated they would provide, “guidance to field elements encouraging participation in the Defense Suicide Event Report submission process.”

Our Response

The comments from the Naval Criminal Investigative Service are responsive and no additional comments are required.

Air Force Office of Special Investigations Comments

The Air Force Office of Special Investigations concurred with the recommendation and stated, “AFOSI will participate as needed in the Department of Defense suicide event report submission process, as well as in the proposed Suicide Event Boards to ensure information obtained throughout an investigation is available.”

Our Response

The comments from the Air Force Office of Special Investigations are responsive and no additional comments are required.



Appendix A

Scope and Methodology

We conducted this assessment from June 2013 to August 2014 in accordance with the Council of Inspectors General on Integrity and Efficiency, “Quality Standards for Inspections and Evaluations,” January 2012. We planned and performed the assessment to obtain sufficient and appropriate evidence to provide a reasonable basis for our observations and conclusions, based on our assessment objectives.

This assessment focused on DoDSER death submissions that had a high number of “don’t know/data unavailable” responses. The assessment examined the policy, software, and training related to DoDSER submissions. Existing law enforcement investigations, command investigations, and medical records were used; the assessment team did not conduct their own investigation into the suicide death.

This assessment did not address accuracy of the supporting documentation or investigations because the medical examiner and/or law enforcement agency is considered the definitive source. The assessment did not address the accuracy of the non-“don’t know/data unavailable” data points because it would have greatly increased the scope, time, and resource requirements for conducting this assessment. The assessment did not address the sensitivity or specificity of the existing DoDSER questions and responses because it would have increased the scope, time, and resource requirements for conducting this assessment.

We collected and reviewed publications from the Centers for Disease Control and Prevention’s (CDC) National Violent Death Report System (NVDRS), the VA’s Suicide Prevention Action Network (SPAN), DoD directives and instructions, and relevant civilian and military literature on suicide data collection and surveillance. We also reviewed information on DoDSER policies and procedures collected from the Services and MCIOs through data calls, site visits, interviews, and briefings to the DoD IG.

We visited or contacted individuals who participated or informed the DoDSER process at various installations to include Army, Navy, Marine Corps, and Air Force personnel. The in-brief/kick-off meeting occurred July 24, 2013 in Arlington, Virginia. A follow-up meeting occurred with USMC personnel on July 31, 2013 at Quantico Marine Corps Base, Virginia. The team also met with MCIOs in Quantico, Virginia. The team met with the Air Force Suicide Prevention Program Manager on September 10, 2013.

Subsequently, we visited the following:

- Joint Base Lewis-McCord, Washington – I Corps, Madigan Army Medical Center, and the National Center for Telehealth and Technology;
- Fort Bragg, North Carolina – Womack Medical Center and XVIII Airborne Corps;
- Fort Drum & Canandaigua, New York – Guthrie Army Health Clinic, Drum Army CID, and Canandaigua VA Medical Center/Military Crisis Line;
- Marine Corps Base Camp Lejeune, North Carolina – II Marine Expeditionary Force and Navy Criminal Investigative Service;
- Naval Station Norfolk, Virginia – U.S. Fleet Forces Command; and
- Joint Base Langley-Eustis, Virginia – 633rd Medical Operations Squadron Behavioral Health Clinic.

The DoDSER assessment report chronology was:

June-July 2013	Research and fieldwork in NCR
August 2013-January 2014	Research and fieldwork in CONUS
September 2013-August 2014	Analysis and report writing
August 12, 2014	Draft assessment report issued
October 3, 2014	Management comments received and evaluated
November 14, 2014	Report published

Use of Computer-Processed Data

We utilized computer-processed data in this assessment: spreadsheets, output from databases, and internet-based statistical analysis websites. We did not independently assess the reliability of each file provided, to include: formula verification, report output formats, etc. Observations and recommendations were not based solely on information obtained from computer processes or documents, but from interviews, and manual reviews of DoDSER submissions and MCIO data records.

Use of Technical Assistance

We received technical assistance during the assessment from OIG's Quantitative Methods Division (QMD) in the statistical sample and testing for significance. See Appendix B for details.

Prior Coverage

No prior coverage has been conducted on the DoDSER during the last 5 years.

The Government Accountability Office (GAO) had issued several reports on VA and DoD electronic health records. Their latest report, dated February 2014, provided a comprehensive overview of past reports and recommended, "the departments develop plans for interoperability." Unrestricted GAO reports can be accessed online at <http://www.gao.gov>.

GAO

Report No. 14-302, "Electronic Health Records, VA and DoD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration," February 2014

Appendix B

Quantitative Analysis of Data

As described in the “Data Collection and Analysis Methodology” section of this report, phase 1 of the assessment included two distinct methodological steps. Step 1 of the analysis used 28 DoDSER cases that were missing at least 75 percent of their data. Step 2 used a stratified random sample of 52 DoDSER cases taken from 98 DoDSER cases missing between 25 and 75 percent of their data. This section of the report presents the mathematical and statistical analysis that was conducted on this data.

Both steps compared DoDSER submissions to the corresponding MCIO death investigations to determine the availability of information relevant to DoDSER submissions. The MCIO death investigation files were deemed the most efficient method for identifying missing information from the DoDSER submission.

Step 1:

Step 1 was a review of 28 DoDSER cases missing at least 75 percent of required information. These submissions had between 57 and 75 items marked “don’t know/ data unavailable.” We reviewed all 28 death investigations to identify ten different DoDSER topics.

1. Was alcohol used prior to death?
2. Were prescription medications used prior to death?
3. Were illicit drugs used prior to death?
4. Had the decedent been treated for any medical condition within 90 days prior to death?
5. Had the decedent been treated for a behavioral health condition within 90 days prior to death?
6. Did the decedent have an active prescription for behavioral health medications?
7. Did the decedent have a history of failed relationship with a significant other?
8. Did the decedent leave a suicide note?
9. Did the decedent communicate their intention to die in advance?
10. Did the decedent have any history of previous suicide attempts?

The following table (Table 6. Review of 28 Cases Percentage and [Number]) indicates the result of this review of the death investigations. All 28 DoDSER cases had a corresponding death investigation.

Table 6. Review of 28 Cases Percentage and (Number)

	Alcohol Involved at Time of Death	Prescription Medication Involved at Time of Death	Illicit Drugs Involved at Time of Death	Current Medical Condition (within 90 days of death)	Current Behavioral Health Treatment
Yes	32.14 (9)	14.29 (4)	3.57 (1)	35.71 (10)	32.14 (9)
No	39.29 (11)	57.14 (16)	67.86 (19)	17.86 (5)	21.43 (6)
Unknown	28.57 (8)	28.57 (8)	28.57 (8)	46.43 (13)	46.43 (13)

	Behavioral Health Medications	Failed Relationship	Suicide Note	Communicated Intent	Previous Suicide Attempts
Yes	17.86 (5)	57.14 (16)	42.86 (12)	25.00 (7)	17.86 (5)
No	35.71 (10)	42.86 (12)	57.14 (16)	75.00 (21)	82.14 (23)
Unknown	46.43 (13)	0.00 (0)	0.00 (0)	0.00 (0)	0.00 (0)

The review of these 28 death investigations indicated that significantly more information about the suicide death was known than was included in the DoDSER submission. Using only one source of information, the death investigation, most of the items we examined were reduced to between 28 and 47 percent “don’t know/data unavailable.” Four items were reduced to zero percent “don’t know/data unavailable” (failed relationship, suicide note, communicated intent, and previous suicide history). Therefore, we concluded that these 28 DoDSER submissions should have been significantly more complete in the CY 2011 DoDSER Annual Report by using available information.

Step 2:

Step 2 of the data analysis combined the 25-50 percent data “don’t know/data unavailable” (55 cases) group, and the 50-75 percent data “don’t know/data unavailable” (43 cases) group, to create a group of 25-75 percent data “don’t know/data unavailable” responses (98 cases).

We used a stratified random sample from these 98 cases for this analysis, stratified by Service. The 98 cases included 47 Army, 12 USMC, 21 Navy, and 18 Air Force DoDSER submissions.

Since the sample was drawn from only the 25-75 percent “don’t know/data unavailable” group (98 cases), conclusions based on this sample are not generalizable to all 287 deaths in the CY 2011 DoDSER Annual Report. Rather, the goal of this step of the analysis was to show that more information was, in fact, available.

We used a stratified sample design to provide a level of certainty with 90 percent confidence interval and a margin of error of plus or minus seven and one half percent. Two cases initially selected in the sample had MCIO death investigations that had not yet been closed, and were therefore unavailable for our review. Two additional cases were randomly selected from the original 98 as replacements. During the on-site death investigation reviews in Quantico, Virginia, one additional case was still pending MCIO investigation and could not be replaced on site. Therefore, the final sample included 52 cases instead of 53.

Two topics were added to the ten DoDSER topics we reviewed from step 1 (page 54-55) for step 2.

1. Did the decedent have a recent history of financial issues or troubles?
2. Did the decedent have a history of direct combat operations?

Since these DoDSER submissions were missing between 25 and 75 percent of required items (between 19 and 60 items), we focused on answering only those items that were submitted as “don’t know/data unavailable.”

The following table (Table 7. Review of 52 Cases Percentage and [Number]) indicates the result of this review of the death investigations.

Table 7. Review of 52 Cases Percentage and (Number)²⁰

	Alcohol Involved at Time of Death	Prescription Medication Involved at Time of Death	Illicit Drugs Involved at Time of Death	Current Medical Condition (within 90 days of death)	Current Behavioral Health Treatment
Yes	16.67 (4)	16.00 (4)	0.00 (0)	50.00 (26)	54.55 (6)
No	66.67 (16)	60.00 (15)	76.00 (19)	15.38 (8)	18.18 (2)
Unknown	16.67 (4)	24.00 (6)	24.00 (6)	34.62 (18)	27.27 (3)

	Behavioral Health Medications	Failed Relationship	Suicide Note	Communicated Intent	Previous Suicide Attempts
Yes	25.00 (13)	72.22 (13)	40.00 (6)	50.00 (8)	19.05 (4)
No	42.31 (22)	27.78 (5)	60.00 (9)	50.00 (8)	80.95 (17)
Unknown	32.69 (17)	0.00 (0)	0.00 (0)	0.00 (0)	0.00 (0)

	Recent History of Financial Problems	History of Direct Combat Experience
Yes	36.36 (8)	27.27 (6)
No	63.64 (14)	59.09 (13)
Unknown	0.00 (0)	13.64 (3)

The review of these 52 death investigations also indicated that markedly more information about the suicide death was known than was included in the DoDSER submission. Most of the items we examined were reduced to between 16 and 34 percent “don’t know/data unavailable.” Five items were reduced to zero percent “don’t know/data unavailable” (failed relationship, suicide note, communicated intent, previous suicide history, and history of financial problems). Therefore, we concluded that these 52 DoDSER submissions should have been significantly more complete in the CY 2011 DoDSER Annual Report by using available information.

We used the Fisher’s exact test²¹ to determine if the decrease in “don’t know/data unavailable” items was statistically significant. A one-tailed (or one-sided) test was selected because it would have been impossible for the “don’t know/data

²⁰ The numbers presented in this table are only the items originally submitted in the CY 2011 DoDSER as “don’t know/data unavailable,” therefore they do not add up to 52 in each column. The number of items that were “known” in the CY 2011 DoDSER Annual Report is presented in Table 8.

²¹ “Fisher’s exact test is a statistical test used to determine if there are nonrandom associations between two categorical variables.” (<http://mathworld.wolfram.com/FishersExactTest.html>)

unavailable” items to increase. The decrease in the number of “don’t know/data unavailable” between the Pre-Review and Post-Review responses in all 12 items were statistically significant, that is, the improvements (decreases) did not occur by chance.

The following table (Table 8: Statistical Analysis of 52 Case Review) presents the findings of these analyses.

Table 8. Statistical Analysis of 52 Case Review

Alcohol	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	28	24	<0.0001*
Post-Review (MCIO Case Review)	48	4	
Prescription Medication	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	27	25	<0.0001
Post-Review (MCIO Case Review)	46	6	
Illicit Drugs	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	27	25	<0.0001
Post-Review (MCIO Case Review)	46	6	
Current Behavioral Health	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	41	11	<0.0207
Post-Review (MCIO Case Review)	49	3	
Failed Relationship	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	34	18	<0.0001
Post-Review (MCIO Case Review)	52	0	
Financial Issues	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	30	22	<0.0001
Post-Review (MCIO Case Review)	52	0	

* A Fisher Exact One-Tailed P value of .0001 indicates there is a 1 in 10,000 chance the change occurred by chance under the null hypothesis that the “pre-review known” total equals the “post-review known” total for a given DoDSER question

Direct Combat	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	30	22	<0.0001
Post-Review (MCIO Case Review)	49	3	

Suicide Note	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	37	15	<0.0001
Post-Review (MCIO Case Review)	52	0	

Communicated Intent	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	36	16	<0.0001
Post-Review (MCIO Case Review)	52	0	

Suicide History	Known	Unknown	Fisher's Exact One-Tailed P Value
Pre-Review (DoDSER Annual Report)	31	21	<0.0001
Post-Review (MCIO Case Review)	52	0	

All of the Fisher's exact tests were statistically significant to better than the $p=.05$ level indicating that the decrease in "don't know/data unavailable" response was unlikely to be the result of chance. Therefore, the decrease in the number of "don't know/data unavailable" responses in all 12 items were statistically significant improvements.

Appendix C

Proposed DoDSER Submission Checklist

Personnel who are new to the DoDSER data collection process may benefit from guidance and contact information for relevant offices. This proposed checklist provides a list of contacts and source documents for DoDSER death submissions. Note that this checklist may be tailored for specific Service, unit, or installation requirements; maintained at the local level; and provided to DoDSER submitters to initiate data collection.

Suggested Supporting Documents	Potential Source
Autopsy/Toxicology, Police Reports/Sworn Statements, Suicide Note	Military Criminal Investigative Organization (Army CID, NCIS, AFOSI), Local Suicide Prevention Program Manager
Medical/Mental Health Records (Civilian and Military)	Medical/Mental Health Personnel
Personnel Records, Deployment Information	Unit Leadership/Personnel

Suggested Organization Contacts	POC Name	Phone	Email
Military Criminal Investigative Organization (Army CID, NCIS, AFOSI)			
Medical Staff			
Mental Health Staff			
Unit Leadership/Personnel			
Legal/Staff Judge Advocate			
Line of Duty Investigation			
Command Investigation (AR15-6, JAGMAN, etc.)			
Community Support Services (Family Advocacy, Social Work Services, Red Cross, etc.)			
DoDSER/Suicide Prevention local POC			
DoDSER/Suicide Prevention regional or Service POC			
T2 help line			

List relevant policies below (and may be attached to the checklist):
DoD Policy:
Service Policy:
Local Policy:

Note: It is considered best practice to avoid having a treating behavioral health provider complete the DoDSER case for their patient, in order to avoid any conflict of interest in the reporting of information.

Note: In cases where the individual is deceased, HIPAA regulation allows for the release of protected health information in relation to the death investigation and reporting of the circumstance.

In accordance with C.F.R. Section 164.512 (f)1(c). (refer to link provided below)

(f) Standard: Disclosures for law enforcement purposes. A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(C) (2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought.

(<http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=3f116c7727ef39c2709a48de59fb3363&ty=HTML&h=L&r=SECTION&n=45y1.0.1.3.78.5.27.8>)

Appendix D

DoDSER CY 2012 Annual Report

The CY 2012 DoDSER Annual Report was released on April 25, 2014. There were several areas of marked improvement in the CY 2012 DoDSER data collection. Changes were implemented that impacted data quality and the methodology used for calculating the “rates” of suicide events.

Official data from the Armed Forces Medical Examiner System (AFMES) was used for forensic data (cause of death and substance use at time of death). This improvement helped decreased the rate of “don’t know/data unavailable” responses for alcohol and psychotropic medication use at time of death.

Questions relating to family and social history still had a high percentage “don’t know/data unavailable” items.

Some questions, such as, enrollment in the Personnel Reliability Program and deployment waivers for Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) had a high rate of “don’t know/data unavailable” responses.

Table 9 compares CY 2011 and CY 2012 DoDSER Annual Reports using the CY 2011 top 20 “don’t know/data unavailable” response items.

Table 9. Comparison of CY 2011 and 2012 DoDSER Annual Report “Don’t Know/Data Unavailable” Responses (CY 2011 n=287 and CY 2012 n

Rank	CY 2011 Percent Missing	CY 2012 Percent Missing	DoDSER Item
1	60.8	35.2	Prior to the event, was the decedent an alleged or confirmed victim of emotional abuse?
2	57.3	N/A	Prior to the event, was the decedent seen by chaplain services? (removed from 2012 DoDSER)
3	56.5	57.6	Did the decedent have a family history of mental illness?
4	53.8	6.6	Prior to the event, was the decedent seen by a Military Treatment Facility?
5	53.8	41.8	Personnel Reliability Program (PRP) at the time of the event?
6	49.3	13.8	Prior to the event, was the decedent seen by substance abuse services?
7	47.7	34.9	Prior to the event, was there evidence of a failed or failing other relationship? (non-romantic)
8	47.7	46.2	Prior to the event, was there evidence of a completed suicide by a friend?

Rank	CY 2011 Percent Missing	CY 2012 Percent Missing	DoDSER Item
9	47.6	20.8	Prior to the event, had the decedent taken psychotropic
10	47.6	14.1	During the event, was alcohol used?
11	47.4	25.8	Was there a gun in the home or immediate environment?
12	45.1	34.3	For the job held at the time of the event, did the decedent have job duties or work environments that were unpredictable?
13	44.9	39.6	For the job held at the time of the event, did the decedent have a job that caused him/her to have less than 8 hours of sleep in the 72 hours prior to the event?
14	44.3	32.1	Prior to the event, was the decedent an alleged or confirmed perpetrator of emotional abuse?
15	44.2	39.9	For the job held at the time of the event, did the decedent have stress associated with work environments due to limited resources?
16	43.2	35.9	Was a waiver to deploy required and/or obtained for OIF/OEF?
17	43.2	37.1	Prior to the event, was there evidence of excessive debt or bankruptcy?
18	42.9	43.1	Level of security clearance
19	42.8	17.0	Prior to the event, was the decedent seen by a family advocacy program?
20	42.5	27.7	Did the decedent experience direct combat operations?

Another significant change in the CY 2012 DoDSER Annual Report was the methodology used to calculate suicide deaths rates. In previous Annual Reports, rates were calculated for only active duty personnel. This report, however, included Selected Reserve Component personnel in the four Services separately from Active Component. Since this is the first year that Reserve Component rates were calculated, no previous year rates were available for comparison.



Management Comments

Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs



PERSONNEL AND
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

OCT 3 2014

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Department of Defense Inspector General – Draft Department of Defense Suicide Event Report Data Quality Assessment

Thank you for the opportunity to review and respond to the Inspector General – Draft Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment. I concur with the recommendations that fall within my purview, with comments as noted. Since publication of the 2011 DoDSER, several steps to improve data quality have already been taken to include enhancements to the software, formation of a joint working group to resolve data reporting issues, and publishing guidance within Department of Defense Directive 6490.14, Defense Suicide Prevention Program, dated June 18, 2013, which addresses data collection, standardization, and reporting procedures that will inform suicide prevention policies, programs, and research.

Continuing to work closely with the Department of Veterans Affairs, enhancements in data quality, and improving the completeness of DoDSER submissions are essential to sound surveillance and suicide prevention for the Department.

My point of contact on this issue is [REDACTED] Director, Defense Suicide Prevention Office. [REDACTED] can be reached at [REDACTED] or via email at [REDACTED]


Laura J. Jung
Principal Deputy

Attachments:
As stated

Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs (cont'd)

DEPARTMENT OF DEFENSE INSPECTOR GENERAL DRAFT REPORT ON THE DOD SUICIDE EVENT REPORT (DODSER) DATA QUALITY ASSESSMENT

RESPONSE TO RECOMMENDATIONS

Recommendation 1.a: *Under Secretary of Defense (USD) for Personnel and Readiness (P&R) publish guidance on the Department of Defense Suicide Event Report submission process to require:*

1. *initiating Department of Defense Suicide Event Reports within 30 days of suspected suicide death,*
2. *completing Department of Defense Suicide Event Report submission no earlier than the Armed Forces Medical Examiner determination that the death was a result of suicide and no later than 60 days after the Armed Forces Medical Examiner determination,*
3. *allowing the first Flag/General Officer in a chain of command to authorize an extension for an additional 60 days, and*
4. *eliminating the 180 day auto-archive requirement on open Department of Defense Suicide Event Report death records.*

DoD Response:

We concur with the recommendation, with comments.

- We are drafting guidance for the DoD Components that will include the proposed time lines. Our target to publish this guidance is January 2015.
- We had already identified the elimination of the 180 day auto-archive requirement as an area that needs improvement, and are coordinating a modification to the System of Records Notice (SORN), which is the primary regulatory change needed. We expect to have draft guidance in coordination by April 2015.

Recommendation 1.b: Not Applicable.

Recommendation 2.a: *Under Secretary of Defense for Personnel and Readiness publish guidance requiring suicide event boards to establish a multidisciplinary approach for obtaining the data necessary to make comprehensive Department of Defense Suicide Event Report submissions. For each suicide death this board should:*

1. *be a locally (command or installation level) chartered board with defined task, purpose, and outcome for each suicide death review,*
2. *include participation by unit leadership, medical/mental health, and Military Criminal Investigative Organizations, and*
3. *articulate the requirement to appropriately share information (for example, medical and law enforcement reports) from ongoing investigations.*

Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs (cont'd)

DoD Response:

We concur with the recommendation. We believe it is valuable to provide DoD support to the Services to ensure consistent guidance and continuity for the local boards and to resolve any joint issues. We will have draft guidance in coordination by April 2015 requiring suicide event boards to establish a multidisciplinary approach for obtaining required data, and will include this recommendation in the draft DoD Instruction (DoDI) to DoD Directive (DoDD) 6490.14.

Recommendation 2.b: Not Applicable.

Recommendation 3.a: *Under Secretary of Defense for Personnel and Readiness, in accordance with Recommendation 2.a, publish guidance requiring a suicide event board to enable a multidisciplinary approach for obtaining the data required to make a comprehensive Department of Defense Suicide Event Report submission.*

DoD Response:

We concur with the recommendation and will incorporate it into planned guidance, noted in our response to Recommendation 2.a.

Recommendation 3.b: *Director, National Center for Telehealth & Technology modify the Department of Defense Suicide Event Report software to:*

1. *allow some Department of Defense Suicide Event Report responses to be "No Known History of XXX,"*
2. *modify some DoDSER responses to require an explanation/justification for any "don't know/data unavailable" response, and*
3. *refine user/technical assistance into the Web-based Department of Defense Suicide Event Report submission forms (pop-up help with instructions and possible sources of information [for example, medical record, Military Criminal Investigative Organization, personnel file]).*

DoD Response:

We concur with the recommendation and will implement changes by January 1, 2016.

Recommendation 3.c: *Director, National Center for Telehealth & Technology conduct after action reviews of selected Department of Defense Suicide Event Report submissions directly with submitters in order to identify what they perceived as confusing questions.*

DoD Response:

We concur with the recommendation and will begin implementing after action reviews on January 1, 2015.

Recommendation 3.d: Not Applicable.

Recommendation 4.a: *Under Secretary of Defense for Personnel and Readiness authorize senior*

Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs (cont'd)

commanders to produce unit/installation reports to better understand suicide trends, make informed local suicide prevention policy, and relate their trends to Service and DoD trends.

DoD Response:

We concur with the recommendation, and will include it in planned guidance, noted in our response to Recommendation 2.a. Command/unit access to reports in a timely fashion will allow immediate steps to be implemented regarding postvention responses for the unit. Implementation must address privacy concerns, especially with regard to non-fatal suicide attempts.

Recommendation 4.b: *Director, DHA update policy to recognize manpower credit expended for Department of Defense Suicide Event Report workload in the Medical Expense and Performance Reporting System.*

DOD Response:

We concur with this recommendation, with comments. The Medical Expense and Performance Reporting System (MEPRS) is a managerial cost accounting system and not a workload reporting system for capturing manpower credit. We disagree with Observation 4, "Medical manpower/workload accounting did not enable military treatment facilities to appropriately take credit for the level of effort to support DoDSER data collection and submission. This workload was considered overhead rather than suicide prevention activities." The completion of the DoDSER on the event of a suicide does not fit the definition of patient care or overhead activity. The time supporting the completion of the report should not be reported in the intermediate overhead (support services), ancillary (e.g., pharmacy, laboratory) or final patient care (e.g., inpatient, ambulatory) MEPRS expense accounts.

Although MEPRS does not define manpower credit or direct the utilization of MEPRS data by the Services for determining Military Treatment Facility (MTF) staffing levels, we agree that labor expended in producing the DoDSER should be captured and salaries distributed to a final operating expense account for resource performance purposes. The DoDD 6010.13-M, Medical Expense and Performance Reporting System, currently allows for capturing time supporting this function in functional category "F" Special Programs.

The DHA MEPRS Program Office will work through the Services' MEPRS Program Office points of contact (POCs) to clarify, determine, and standardize in which MEPRS Special Program summary and sub-account the DoDSER labor hours will be reported. Based on recent discussions with the Service MEPRS POCs, it is our understanding that the problem being identified is caused by varying interpretations of current MEPRS guidance. The estimated completion date for developing a standardized approach for recording DoDSER labor hours is six (6) months from the date of this report being issued.

Recommendation 4.c: *Director, National Center for Telehealth & Technology, upon receipt of authority resulting from Recommendation 4.a, update software to allow unit/installation trend reports.*

Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs (cont'd)

DoD Response:

We concur with the recommendation, and will develop procedures to ensure appropriate coordination of publicly released reports and a unified approach to analyzing and standardizing data.

Recommendation 4.d: *Director, National Center for Telehealth & Technology perform annual independent quality assurance reviews of a representative sample of Department of Defense Suicide Event Report submissions to identify opportunities for improving data quality.*

DoD Response:

We concur with the recommendation, and expect to conduct the first review not later than December 31, 2015.

Recommendation 4.e: Not Applicable.

Recommendation 5: *Director, Defense Health Agency improve data sharing of healthcare information with the VA by:*

1. *identifying the relevant data sources that would enable improved understanding of Service members' medical conditions and prior treatments when they call the Veterans/Military Crisis Line, and update the appropriate System of Record Notifications to allow for sharing of relevant DoD clinical data with the Military Crisis Line,*
2. *developing a process for Veterans/Military Crisis Line staff to refer Service members back to the Military Health System or other appropriate medical care to improve continuity of care by ensuring the Military Health System is informed of crisis care provided, and*
3. *coordinating with the Veterans Affairs to ensure policies are established to appropriately manage privacy issues.*

DoD Response:

We concur with the underlying premise of this recommendation, and your acknowledgement that it is outside the scope of this assessment. The Department of Defense strongly supports process improvement which will better enable the Crisis Line staff to expeditiously match the caller with appropriate care. However, we believe this specific recommendation is premature, and that facilitating improvement requires careful consideration of broader questions to develop a holistic approach to improve performance where needed. The DoD will undertake this review.

Recommendation 6: *Director, Defense Health Agency:*

- a. *update appropriate System of Record Notification to allow for sharing of DoD Suicide Event Report data with the Department of Veterans Affairs to enable health surveillance, as required by DoDD 6490.02E.*

Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs (cont'd)

- b. coordinate with Department of Veterans Affairs to ensure appropriate policies are established to manage privacy issues while sharing Department of Defense Suicide Event Report data.*

DoD Response:

We concur with the recommendation. We will examine the existing SORN to determine whether an amendment would be necessary to enable appropriate sharing of health surveillance data to the extent necessary under DoDD 6490.02E.

Recommendation 7: Not Applicable.

Director, National Center for Telehealth and Technology

REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

12 SEP 2014

MCIR

MEMORANDUM FOR Department of Defense Inspector General, Special Plans and Operations, ATTN: [REDACTED] 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to DODIG Draft Report, Department of Defense Suicide Event Report Data Quality Assessment (Project No. D2013-D00SPO-183)

1. Thank you for the opportunity to review this assessment report. Our comments are enclosed for your consideration.
2. Our point of contact is [REDACTED] Internal Review and Audit Compliance Office, [REDACTED] or email: [REDACTED]

FOR THE SURGEON GENERAL:

Encl

ULDRIC L. FIORE, JR.
Chief of Staff

Director, National Center for Telehealth and Technology (cont'd)

U.S. Army Medical Command (MEDCOM) and Office of the Surgeon General (OTSG)

Comments on DODIG Draft Assessment Report DOD Suicide Event Report Data Quality (Project No. D2013-D000SPO-183.000)

RECOMMENDATION 3.b.: Modify the Department of Defense Suicide Event Report (DODSER) software to:

1. Allow some Department of Defense Suicide Event Report responses to be "No Known History of XXX."
2. Modify some Department of Defense Suicide Event Report responses to require an explanation/justification for any "don't know/data unavailable" response.
3. Refine user/technical assistance into the Web-based Department of Defense Suicide Event Report submission forms (pop-up help with instructions and possible sources of information [for example, medical record, Military Criminal Investigative Organization, personnel file]).

RESPONSE: Concur. The National Center for Telehealth & Technology will:

1. Propose a list of items for concurrence by the Services' DODSER Program Managers that will change the "No" response options to "No Known History of XXX."
2. Modify some DODSER responses to require an explanation/justification for any "don't know/data unavailable" response.
3. Refine existing pop-up help instructions that provide coding guidance by modifying the text to suggest possible sources of information.

The anticipated implementation date for these changes is 1 January 2016.

RECOMMENDATION 3.c.: Conduct after action reviews of selected Department of Defense Suicide Event Report submissions directly with submitters in order to identify what they perceived as confusing questions.

RESPONSE: Concur. The National Center for Telehealth & Technology will develop and implement a plan to conduct after action reviews of selected DODSER submissions by 1 January 2015.

Encl

Director, National Center for Telehealth and Technology (cont'd)

RECOMMENDATION 4.c.: Upon receipt of authority from the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) to authorize senior commanders to produce unit/installation reports to better understand suicide trends, make informed local suicide prevention policy, and relate their trends to Service and DoD trends, update software to allow unit/installation trend reports.

RESPONSE: Concur. On receipt of authority from USD(P&R) and approval from DHA, the Center will update DODSER software to allow unit/installation trend reports with aggregated, de-identified data. Procedures will be developed to ensure appropriate coordination of publically released reports and a unified approach to analyzing and standardizing data.

RECOMMENDATION 4.d.: Perform annual independent quality assurance reviews of a representative sample of Department of Defense Suicide Event Report submissions to identify opportunities for improving data quality.

RESPONSE: Concur. The Center will develop a plan to conduct annual independent reviews to identify opportunities for improving data quality by 1 January 2015, and conduct the first review by 31 December 2015.

Army Chief of Staff



DEPARTMENT OF THE ARMY
OFFICE OF THE DEPUTY CHIEF OF STAFF G-1
300 ARMY PENTAGON
WASHINGTON, DC 20310-0300

DAFE-AR-SP

16 September 2014

MEMORANDUM FOR Department of Defense Inspector General (DoDIG), Special Plans and Operations, 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Response to the draft Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment (Project No. D2013-DOO-SPO-183.000), dated 12 August 2014.

1. Thank you for the opportunity to review the report.
2. The HQDA G1, ARD, Suicide Prevention Office concurs with the recommendations requiring comment from the Army Chief of Staff.
4. The point of contact is [REDACTED] Chief, Army Suicide Prevention Office,
[REDACTED] or email: [REDACTED]

A handwritten signature in black ink, appearing to read "Hardee Green", is positioned above the printed name.

HARDEE GREEN
COL, LG
Deputy Director, Army Resiliency Directorate

Chief of Naval Operations

OPNAV N171 Review Form

Subject:	DoDIG DoDSER Data Quality Assessment Draft Report	Tasker #: N/A
Reviewed by SME/AO:	██████████ SME, OPNAV N171	AO Code: N171
What is N171 Equity:	DoDIG requests comments on the draft report in regarding their recent DoD-wide DoDSER (Dept of Defense Suicide Event Report) Data Quality Assessment. This assessment was performed in response to the service's concerns regarding the high number of "I don't know" responses on suicide death DoDSERs.	
Comments (attached SD818)	Inputs provide in attachments or comments	
Recommendation	Concur w/comments and recommended edits	
Reviewing Branch Head:	██	Date: 16 Sep 2014

Chief of Naval Operations (cont'd)

[UNCLASSIFIED]

COMMENTS MATRIX FOR DoD ISSUANCES: DoDIG DoDSER Data Quality Assessment Draft Report							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E-MAIL	PAGE #	PARA #	COMMENT TYPE (C/S)	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/R/P
1	U	OPNAV N17 [REDACTED]	15	Last sentence of Obser #1 block	S	<p>Coordinator Comment: How was this as the reason for "I don't know" responses determined? Was this assumed, stated by one individual, or was this backed up by data?</p> <p>Coordinator Justification: In most cases, I believe other reasons for these responses are more likely. When we discuss the DoDSER with command personnel, this reason has never, or extremely rarely, been given. Lack of effort in obtaining additional information, lack of understanding of the importance of completeness and accuracy of data, lack of knowledge on how to access multiple sources of data, and lack of belief in right to access HIPAA-related data, and lack of knowledge of decedent's thoughts and/or things the decedent kept private are more common reasons which have nothing to do with whether death has been confirmed by AFME or whether further investigations are underway. The multidisciplinary approach to completing DoDSER in a review board should address this problem as much as feasible regardless of when it occurs. Recommendation 1.a (page 18) also takes a good approach to this by having the DoDSER started early to capture information, and allowing it to remain open later for maximum data collection.</p> <p>Originator Justification for Resolution:</p>	
2		OPNAV N17 [REDACTED]	18	Rec 1.a #2, #3.	S	<p>Coordinator Comment: These are good recommendations, but one issue needs to be addressed. How will this affect the end-of-year DoDSER reports and requirement to have all of them (regardless of confirmed or not) in by the end of March?</p> <p>Coordinator Justification: This may need to move to the end of June. Regardless, leadership will need to be apprised of the fact that end of year DoDSER reports will never be 100% complete or comprehensive. Deaths and DoDSERs which are confirmed late will be left out of analyses, pushed into the 'wrong year' analyses, or analyzed every few years (Navy's numbers will be too small to analyze annually) separately to see if their data is any different than their proper year group.</p> <p>Originator Justification for Resolution:</p>	

SD FORM 818, DEC 07

[CLASSIFICATION]

1

Chief of Naval Operations (cont'd)

[UNCLASSIFIED]

COMMENTS MATRIX FOR DoD ISSUANCES: DoDIG DoDSER Data Quality Assessment Draft Report							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E-MAIL	PAGE #	PARA #	COMMENT TYPE (C/S)	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/R/P
3		OPNAV N17 [REDACTED]	21	Rec. 2.a, Para 1	S	<p>Coordinator Comment: Recommend adding 'This board should be convened as soon as possible once AFME has confirmed the death as suicide. This will allow both for preservation of data and memories regarding events related to the suicide as well as sufficient time to obtain any additional data to allow maximum DoDSER completeness prior to the 60-day post-AFME determination window.'</p> <p>Coordinator Justification: Clarification to avoid convening of board before AFME determination. Similar reasons as to why we do not want DoDSER officially started or submitted until after same.</p> <p>Originator Justification for Resolution:</p>	
4		OPNAV N17 [REDACTED]	27-28	Disc Para 1 Para 2 Para 3	S	<p>Coordinator Comment: This is a controversial issue and one which warrants more discussion. It probably should not be part of the report as the source info is from those who are understandably curious and want access to such information but who, as non-SP SME's, do not necessarily understand there are major problems with this. One problem with this is tracking numbers is one thing, but analysis and interpretation of such small numbers, at least for Navy, and subsequent actions based upon them, can be very dangerous. We do not want non-SME's performing trend analysis or comparing raw data to make conclusions. For the Navy, this is OPNAV's job. The annual DoDSER report provides such information as well, already analyzed with trends, etc. There is little to no utility in analyzing regional or command data separately, despite periodic requests or orders for this, and despite the curiosity of some to do so themselves. Invariably, misguided assumptions and conclusions are made when this happens. This practice, at best, wastes valuable resources that could be directed at evidenced-based suicide prevention efforts. At worst, such endeavors can do harm by driving misguided actions which cause suicide contagion or attribute causality or blame where none exists.</p> <p>Coordinator Justification:</p>	

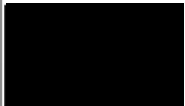
SD FORM 818, DEC 07

[CLASSIFICATION]

2

Chief of Naval Operations (cont'd)

[UNCLASSIFIED]

COMMENTS MATRIX FOR DoD ISSUANCES: DoDIG DoDSER Data Quality Assessment Draft Report							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E-MAIL	PAGE #	PARA #	COMMENT TYPE (C/S)	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/R/P
						Originator Justification for Resolution:	
5		OPNAV N17 	28	Disc Para 3	S	<p>Coordinator Comment: Recommend clarification here that this is referring to “Command and/or Installation Level” Service lessons learned process...that is, presuming this is referring to lessons learned about suicide. If this is referring to lessons learned about completion of the DoDSER, then that should be clarified.</p> <p>Coordinator Justification: Navy does include DoDSER data collection as part of our Service lessons learned (about Navy suicides) process, at the OPNAV N17 level. This is accomplished in our annual Cross-Disciplinary Suicide Case Reviews of all Navy suicides. This is similar to a Suicide Event Board concept except it occurs at the OPNAV level rather than the Command or Installation level. DoDSERs are used as one data source. NCIS is an active and indispensable participant in these reviews. With regard to completion of the DoDSER lessons learned, OPNAV N171 staff constantly assist commands with questions and assistance on DoDSER related issues and data quality has markedly improved due to these efforts.</p> <p>Originator Justification for Resolution:</p>	

Chief of Naval Operations (cont'd)

[UNCLASSIFIED]

COMMENTS MATRIX FOR DoD ISSUANCES: DoDIG DoDSER Data Quality Assessment Draft Report							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E-MAIL	PAGE #	PARA #	COMMENT TYPE (C/S)	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/ R/ P

INSTRUCTIONS FOR COMPLETING SD FORM 818

COORDINATING OSD COMPONENT: Use this form to provide critical and substantive comments to the OSD Component that originated the issuance. Complete the classification header and footer, columns 1 through 5, and the first two entries in column 6. Upload the completed form to the DoD Directives Program Portal IN MICROSOFT WORD FORMAT, with a scanned copy of the sign SD Form 106, "DoD Directives Program Coordination Record," or coordination memorandum.

ORIGINATING OSD COMPONENT: Use this form to consolidate comments from all coordinators and to record adjudication of the comments. (To add comments from an SD 818 submitted by a coordinator, use the "Copy" and "Paste" tools on the Microsoft Word Standard Toolbar.) When consolidating comments, place them in the order of the pages/paragraphs they apply to (e.g., all comments from all coordinators that apply to page 1, paragraph 1.a., should be grouped together as the initial entries; all comments that apply to page 1, paragraph 1.b., should be grouped together next, and so on). Complete column 7 and the third entry in column 6. Adjust the classification header and footer and columns 1 and 2 as appropriate.

CLASSIFICATION – Enter the highest classification of the comments. If all are unclassified, mark the header and footer accordingly and ignore the column.

COLUMN 1 – Enter the number of the comment. Enter comments in the order of the pages/paragraphs they apply to.

COLUMN 2 – Enter the classification of the comment. If all comments are unclassified, mark the header and footer accordingly and ignore the column.

COLUMN 3 – Enter the appropriate information.

COLUMN 4 – Enter the appropriate information.

COLUMN 5 – Enter the appropriate information.

COLUMN 6 – Enter the comment type. Place only one comment per row. Do NOT include administrative comments concerning non-substantive aspects of an issuance, such as dates of references, organizational symbols, and/or grammatical errors.

(C) **CRITICAL:** When a Component has one or more critical comments, that Component's coordination shall reflect a nonconcur. Critical comments identify:

- Violations of the law or contradictions of Executive Branch policy or of policy established in DoD issuances. The GC, DoD, or his or her representative shall identify legal objections as critical comments.
- Unnecessary risks to safety, life, limb, or DoD materiel; waste or abuse of DoD appropriations; or imposition of an unreasonable burden on a Component's resources.

(S) **SUBSTANTIVE:** Substantive comments are made when a section in the issuance appears to be or is potentially unnecessary, incorrect, misleading, confusing, or inconsistent with other sections, or when a Component disagrees with the proposed responsibilities, requirements, and/or procedures. A substantive comment is usually not sufficient justification for a Component to nonconcur on an issuance. Several substantive comments when taken together may be grounds for a nonconcurrency.

COLUMN 7 – COORDINATING COMPONENT: Enter the comment in the area provided. Enter your justification for the comment and your requested or recommended changes in the area provided. You must provide convincing support for critical comments in the justification.

– **ORIGINATING COMPONENT:** Enter your justification for disposition of the comment in the area provided. Include any related communications with the coordinating Component. You must provide convincing support for rejecting critical comments.

COLUMN 8 – Enter whether you accepted (A), rejected (R), or partially accepted (P) the comment. Your justification for disposition of the comment in column 6 must be consistent with this entry.

Commandant of the Marine Corps

1754

MFC

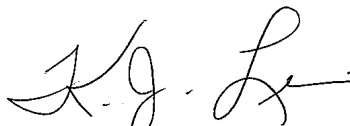
05 SEP 2014

MARINE AND FAMILY PROGRAMS DIVISION COMMENTS on MCATS TASKER
2014-8-942

Subj: DRAFT DODSER ASSESSMENT REPORT 15 SEP 14

1. Marine and Family Programs Division reviewed the subject document in accordance with tasking requirements and concurs without comment.

2. Point of contact is [REDACTED], Branch Head,
MFC at [REDACTED].



K. J. LEWIS

By direction

Air Force Chief of Staff



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

5 September 2014

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
ATTN: [REDACTED]

FROM: AF/SG3
7700 Arlington Blvd
Falls Church, VA 22042

SUBJECT: Department of Defense Suicide Event Report (DODSER) Data Quality Assessment

Thank you for the opportunity to review and comment on the DoDSER Data Quality Assessment Report. Assessment of data quality of the DoDSER is vital to the Services' suicide prevention efforts to assure we have the most accurate information collected to help inform the suicide prevention policy and decision making. The Air Force concurs with comments on the DoDSER Data Quality Assessment.

The AF/SG POC is [REDACTED] or
[REDACTED]

CHARLES E. POTTER
Brigadier General, USAF, MSC
Assistant Surgeon General
Health Care Operations

Attachment:
Comment Matrix

Air Force Chief of Staff (cont'd)

SELECT A CLASSIFICATION

COMMENTS MATRIX FOR DoD ISSUANCES: "DoD IG DoDSER Data Quality Assessment"							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E-MAIL	PAGE	PARA	COMMENT TYPE	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/R/P

HOW TO USE THE SD FORM 818

GENERAL GUIDANCE:

- To **sort the table** by page number, hover your mouse over the top of the first cell in the column until a downward arrow appears; click to select the entire column. Under Table Tools, select Layout, and then click Sort and "OK." To **add new rows**, copy and paste a blank row to keep consistent formatting. To **add automatic numbering to column 1**, select the entire column and then click on the Numbering button under Paragraph on the Home ribbon.

IF YOU ARE THE COORDINATING OSD COMPONENT:

- Use this form to provide critical and substantive comments to the OSD Component that created the issuance. Complete the header and footer, columns 2-6, and the first two entries in column 7:

COLUMN 1 Order comments by the pages/paragraphs that they apply to in columns 4 and 5.

COLUMN 2 Enter the classification of the comment. If all comments are unclassified, mark the header and footer and ignore the column.

COLUMNS 3, 4, AND 5 Enter the appropriate information for **each** comment.

COLUMN 6 Enter comment type (C or S). **Do not include administrative comments** such as reference dates or grammatical errors.

(C) CRITICAL: When a Component has one or more critical comments, that Component's coordination is an automatic nonconcur. The justification for critical comments **MUST** identify violations of law or contradictions of Executive Branch or DoD policy; unnecessary risks to safety, life, limb, or DoD materiel; waste or abuse of DoD appropriations; or imposition of an unreasonable burden on a Component's resources.

(S) SUBSTANTIVE: Make a substantive comment if a part of the Issuance seems unnecessary, incorrect, misleading, confusing, or inconsistent with other sections, or if you disagree with the proposed responsibilities, requirements, or procedures. One substantive comment is usually not sufficient justification for a nonconcur on an issuance. Multiple substantive comments may be grounds for a nonconcur.

COLUMN 7 Place only one comment per row. Enter your comment, recommended changes, and justification in the first two areas provided. **YOU MUST PROVIDE CONVINCING SUPPORT FOR CRITICAL COMMENTS IN THE JUSTIFICATION.**

- Review** the comments, **resolve** any conflicting views, and **confirm** that the completed matrix accurately represents your Component's position. Upload the form to the DoD Directives Program Portal in **Microsoft Word format (.docx)**, with the signed SD Form 106 or coordination memorandum.

IF YOU ARE THE ORIGINATING OSD COMPONENT:

- Consolidate comments from all coordinators and adjudicate them. Leave columns 4 and 5 blank for general comments that apply to the whole document. **Sort comments** by the pages/paragraphs to which they apply using the **General Guidance** sort feature (e.g., all comments from all coordinators that apply to page 1, paragraph 1.a., should be together; all comments that apply to page 1, paragraph 1.b., should be next). Set classification header, footer, and columns 1 and 2 as appropriate. Complete last entry in column 7, and column 8:

COLUMN 7 If you rejected or partially accepted a comment, enter your justification in the originator justification area. Leave blank if you accepted it. Include any related communications with the coordinating Component. You **MUST** provide convincing support for rejecting critical comments.

COLUMN 8 Enter whether you accepted (A), rejected (R), or partially accepted (P) the comment. Your justification in column 7 must be consistent with this entry.

SD FORM 818, AUG 12

ALL PREVIOUS EDITIONS ARE OBSOLETE AND SHOULD NOT BE USED

1

SELECT A CLASSIFICATION

Air Force Chief of Staff (cont'd)

SELECT A CLASSIFICATION							
COMMENTS MATRIX FOR DoD ISSUANCES: "DoD IG DoDSER Data Quality Assessment"							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E-MAIL	PAGE	PARA	COMMENT TYPE	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/R/P
1	U	USAF/AFMSA	18	Rec 1.a.3	S	<p>Coordinator Comment: The AF believes it can implement the intent of the extension request by using the structure of the AF Community Action Information Board/Integrated Delivery System (CAIB/IDS) and the current suicide prevention program. The installation CAIB chair, usually the Installation CC or designee can apply through the MAJCOM CAIB/IDS for a one-time 60 day extension to the HAF IDS through the AF Suicide Prevention Program Manager.</p> <p>Coordinator Justification: Service specific process.</p> <p>Originator Justification for Resolution:</p>	Choose an item.
2	U	USAF/AFMSA	21	2.a.1-2.a.3		<p>Coordinator Comment: In consideration of death review processes currently under review in the AF, the implementation of these recommendations could work for the AF at the installation level with the installation SPPM/DoDSER POC leading the suicide event board and data collection.</p> <p>Coordinator Justification: Service Specific process.</p> <p>Originator Justification for Resolution:</p>	
3	U	USAF/AFMSA	27	4.a and 4.c		<p>Coordinator Comment: For the AF the implementation of these recommendations would work at the MAJCOM level where the incidence numbers of suicide attempts and suicides approach the level that would lend them to trend analysis. The MAJCOM Mental Health Consultants have the ability to pull/interpret reports and provide the appropriate statistical caveats for leadership. This function is currently in place.</p> <p>Coordinator Justification: Service Specific process.</p> <p>Originator Justification for Resolution:</p>	Choose an item.

SD FORM 818, AUG 12

ALL PREVIOUS EDITIONS ARE OBSOLETE AND SHOULD NOT BE USED

2

SELECT A CLASSIFICATION

Air Force Chief of Staff (cont'd)

SELECT A CLASSIFICATION							
COMMENTS MATRIX FOR DoD ISSUANCES: "DoD IG DoDSER Data Quality Assessment"							
#	CLASS	COMPONENT AND POC NAME, PHONE, AND E- MAIL	PAGE	PARA	COMMENT TYPE	COMMENTS, JUSTIFICATION, AND ORIGINATOR JUSTIFICATION FOR RESOLUTION	A/R/P

Commanding General United States Army Criminal Investigation Command



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
U. S. ARMY CRIMINAL INVESTIGATION COMMAND
RUSSELL-KNOX BUILDING
27130 TELEGRAPH ROAD
QUANTICO, VIRGINIA 222134-2253

CIOP-ZC

17 September 2014

MEMORANDUM FOR Department of Defense Inspector General, Special Plans and Operations, 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Response to the Draft Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment (Project No. D2013-DOO-SPO-183.000), dated 12 Aug 14

1. Thank you for the opportunity to review the report.
2. This command concurs without comment to Recommendation 7 in the draft report.
3. Point of Contact is the undersigned at [REDACTED] or email at [REDACTED]

A handwritten signature in black ink, appearing to read "Guy A. Surian", is positioned above the printed name.

GUY A. SURIAN
Deputy G2/3

Director of the Naval Criminal Investigative Service



DEPARTMENT OF THE NAVY
HEADQUARTERS
NAVAL CRIMINAL INVESTIGATIVE SERVICE
27130 TELEGRAPH ROAD
QUANTICO VA 22134-2253

5580
Ser 23/14U0104
September 15, 2014

From: Assistant Director, Criminal Investigations & Operations Directorate, Naval Criminal Investigative Service
To: Deputy Inspector General, Special Plans and Operations, Office of the Inspector General, Department of Defense
Subj: DEPARTMENT OF DEFENSE SUICIDE EVENT REPORT (DODSER) DATA QUALITY ASSESSMENT (PROJECT NO. D2013-D00SPO-183.000)

Ref: (a) DOD Inspector General Draft Report dated August 12, 2014

1. The Naval Criminal Investigative Service (NCIS) has reviewed Reference (a). NCIS appreciates the opportunity to provide comment on the draft DODIG report.
2. Reference (a) provided one (1) recommendation as follows:
 - Recommendation 7
Commanding General United States Army Criminal Investigation Command, Director of the Naval Criminal Investigative Service, and Commander, Air Force Office of Special Investigations update policy to specifically encourage Military Criminal Investigative Organization participation in the Department of Defense Suicide Event Report submission process, as well as in the proposed Suicide Event Boards (Recommendation 2.a), given available resources and the circumstances of each case, per DoD Instruction 5505.10 guidance.
3. The NCIS agrees with the recommendation to update current policy to encourage NCIS participation in the Department of Defense Suicide Event Report submission process, as well as the proposed Suicide Event Boards. NCIS is in full compliance with SECNAVINST 5430.107, Mission and Functions of the Naval Criminal Investigative Service, which mandates NCIS "Provide to each command, prosecutorial authority or other appropriate activity a full report of investigation regarding any offenses or incidents investigated affecting that entity."

Director of the Naval Criminal Investigative Service (cont'd)

4. NCIS policy will be updated following notification of Suicide Event Board implementation. In the interim NCIS will provide guidance to field elements encouraging participation in the Defense Suicide Event Report submission process.



MARK O. FOX

Commander, Air Force Office of Special Investigations



DEPARTMENT OF THE AIR FORCE
AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS
Quantico Virginia

15 September 2014

MEMORANDUM FOR IG, DoD, ATTN: Director, Assessment Division E/SPO

FROM: HQ AFOSI/XRG
27130 Telegraph Road
Quantico, VA 22134

SUBJECT: AFOSI Response to DoD IG's DRAFT DoDSER Assessment Report (Project No. D2013-DOO-SPO-183.000)

1. This memorandum is the Air Force Office of Special Investigations response to assessment recommendations within DoDIG Project No. D2013-DOO-SPO-183.000 dated August 12, 2014.
2. AFOSI reviewed your comments and concurs with recommendation 7 "Commanding General United States Army Criminal Investigation Command, Director of the Naval Criminal Investigative Service, and Commander, Air Force Office of Special Investigations update policy to specifically encourage Military Criminal Investigative Organization participation in the Department of Defense Suicide Event Report submission process, as well as in the proposed Suicide Event Boards (Recommendation 2.a), given available resources and the circumstances of each case, per DoD Instruction 5505.10 guidance." AFOSI will participate as needed in the Department of Defense suicide event report submission process, as well as in the proposed Suicide Event Boards to ensure information obtained throughout an investigation is available.
3. AFOSI appreciates the opportunity to respond to the DoDSER report. Please contact me if you have any questions about this memorandum.

A handwritten signature in blue ink, appearing to read "J. Poorman", written over a horizontal line.

JAMES K. POORMAN, Special Agent
Director
Strategic Plans and Requirements

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Acronyms and Abbreviations

AFI	Air Force Instruction
AFME	Armed Forces Medical Examiner
AFOSI	Air Force Office of Special Investigations
GAO	Government Accountability Office
CDC	Centers for Disease Control and Prevention
CID	Criminal Investigation Division
CONUS	Continental United States
CY	Calendar Year
DoDI	Department of Defense Instruction
DoDSER	Department of Defense Suicide Event Report
LE	Law Enforcement
MCIO	Military Criminal Investigative Organizations
MCO	Marine Corps Order
ME	Medical Examiner
MEDCOM	Medical Command
MEPRS	Medical Expense and Performance Reporting System
NCIS	Naval Criminal Investigative Service
NCR	National Capital Region
NDAA	National Defense Authorization Act
NVDRS	National Violent Death Report System
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OPNAVINST	Chief of Naval Operations instruction
OTSG	Office of the Surgeon General
POC	Point of Contact
PRP	Personnel Reliability Program
SORN	System of Record Notifications
SPAN	Suicide Prevention and Application Network
SPO	Special Plans and Operations
QMD	Quantitative Methods Division
UCMJ	Uniform Code of Military Justice
USA	United States Army
USAF	United States Air Force
USMC	United States Marine Corps
USN	United States Navy
VA	Department of Veterans Affairs



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U.S. DEPARTMENT OF DEFENSE

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For more information about DoD IG reports or activities, please contact us:

Congressional Liaison

congressional@dodig.mil; 703.604.8324

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